



THE HONG KONG COLLEGE OF PSYCHIATRISTS

Education, Training & Examination

For

Fellowship

2018

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1. ORGANISATION

1.1. The Hong Kong College of Psychiatrists

The role of the College in postgraduate education in psychiatry is to assess and accredit general and higher professional training in psychiatry and to provide specialist designation to accredited medical practitioners. It plays a role in the co-ordination of psychiatric institutes and universities in psychiatric education and training.

The Committees under the Council of the College for the purpose of education and examination include:

- The Education Committee
- The Board of Examiners
- The Review Committee

1.2. The Education Committee

The Committee serves in the following:

- Accreditation and recommendation for approval by the Council of Training Centres/Schemes for general and higher professional training for the Fellowship examinations
- Recognition of psychiatric tutors and psychiatric trainers
- Registration of psychiatric trainees

1.3. The Board of Examiners

This Board serves in the following:

- Setting the requirements for the entry to the fellowship examinations
- Selection of the examiners for the fellowship examinations
- Administration of the fellowship examinations
- Recommendation of successful candidates for election to fellowship

1.4. The Review Committee

It handles the complaints and appeals from candidates of the results of the fellowship examinations.

2. GUIDELINES ON THE EDUCATION AND TRAINING FOR GENERAL AND HIGHER PROFESSIONAL TRAINING FOR FELLOWSHIP EXAMINATION

Organisation of a training scheme

2.1. Training Scheme

For a training scheme to be approved, it must be able to offer a general professional training in psychiatry of at least three years and a higher professional training in psychiatry for another three years.

A training scheme must have at least one College-approved **Tutors' Committee** which is responsible for the running of the training scheme. Rotational training should be administered by the Tutors' Committee of the scheme.

The Tutors' Committee should include College-approved tutor(s) and trainee representative(s).

There should also be an **Education Appointment Committee (EAC)** which is responsible for the appointment, review and termination of psychiatric training status of the trainees. In the EAC, at least one of the members should be a College-approved tutor.

2.2. An Approved Training Scheme

To receive full approval, a scheme must include a broad experience in General Adult Psychiatry and substantial experience in at least four other subspecialties* (Subspecialties referred to specialized training experience required for FHKCPsych only) mentioned below.

For the six years of general and higher professional education, every trainee must have:

A minimum of eighteen months' experience in General Adult Psychiatry, including six months duration of experience of management of patients governed under Part III Cap 136, Mental Health Ordinance, Hong Kong.

A minimum of full time training of six months duration or its equivalent in three of the other subspecialties* apart from General Adult Psychiatry as mentioned below and

A minimum of eighteen months duration of attachment in a subspecialty in the capacity of a senior trainee.

The eighteen months attachment in a subspecialty as a senior trainee can be taken as one of the four subspecialty* experiences required.

Some training in psychological methods of treatment is necessary.

2.3. Duration of Training/Attachments

The total duration of accredited training for Fellowship should be at least six years.

The general professional training should last for at least thirty months,
The higher professional training should last for at least three years after passing the Intermediate Examination or its equivalent.

Attachment in General Adult Psychiatry of a minimum of eighteen months duration is strongly recommended for the first three years of professional training. However, in the event of difficulty of fulfilling this requirement within the said period, trainees are still required to have a minimum duration of General Adult Psychiatry of twelve months in the first three years of general professional training. The remaining 6 months of General Adult Psychiatry training must be made up in the higher professional training period.

Each attachment in a subspecialty* in psychiatry in general should be of at least six months duration. Equivalent part-time experience may also be recognised.

For higher professional training, one of the attachments in a subspecialty* should be of at least eighteen months duration in the capacity of a senior trainee.

2.4. Part-time Training

A trainee should fulfil full-time three years of general professional training.

A senior trainee who plans to have part-time training should submit the application to the Education Committee. The Committee would vet each application case by case.

A part-time trainee should have not less than 50% of the regular supervision and training hour of a full-time trainee. Part-time training with equal to or more than 50% but less than 100% of a full-time training will only be counted as equivalent to 50% of a full-time training period.

2.5. Service Resident

A service resident (as defined by the medical staff rank of the Hospital Authority) may consider applying for retrospective recognition of his/her service provision as a service resident in a recognized psychiatric training centre as six month equivalent training in General Adult Psychiatry, after he/she has entered the psychiatric training scheme in Hong Kong. The recognition of such training should be counted as general professional training only.

2.6. Types of Experience

In organising individual trainee's rotation, consideration needs to be taken of his or her previous experience, special needs and interests.

For experience provided by a scheme, the following guidelines should be followed:

2.6.1. General Adult Psychiatry

Training should generally begin with a period in general adult psychiatry. This must include properly supervised out-patient and in-patient experience, including both new patients and follow-up cases, and supervised experience of emergencies and 'on call' duties.

There should be experience in the management of patients governed by Part III Cap 136, Mental Health Ordinance, Hong Kong.

Some supervised community experience is necessary including domiciliary visits, home assessments with community nurses or social workers. Other experience could include crisis intervention and treatment at home.

All trainees should have experience of

- (a) Working with community psychiatric nurse, social worker, clinical psychologist, and with other professional involved with the patient and his or her family.
- (b) Administering electroconvulsive treatment under approved conditions. A trainer should be identified in each hospital to supervise the teaching and application of electroconvulsive therapy.

2.6.2. Substance Misuse

Attention is drawn to the need to ensure that trainees receive adequate experience in this area. Where there is a separately staffed unit or service for the treatment of alcohol and/or drug problems, it should be possible to offer a full-time or part-time placement.

For this to be regarded as a subspecialty experience, the trainee must spend at least half his/ her time in a range of methods of managing people with alcohol and drug problems.

2.6.3. Child and Adolescent Psychiatry

There should be a significant element of experience in child and adolescent psychiatry, either part-time or full-time. A longer part-time attachment might permit the trainees to follow cases through, but this

has to be balanced against the other advantages which accrue from a full-time attachment.

2.6.4. Forensic Psychiatry

Experience in forensic aspects of psychiatry should be gained wherever possible, by being directly involved in the clinical care of patients referred to consultants with a special interest or responsibility in forensic psychiatry.

It is also valuable for trainees to be accompanied by trainers when patients are seen for medico-legal purposes at prisons, hospitals, remand centres and other establishments. On these occasions trainees may need to prepare "second" reports after a discussion with the trainer.

Trainees should have access to a course of lectures which introduce them to the main principles of forensic psychiatry and medico-legal work.

2.6.5. Liaison Psychiatry

Experience in liaison psychiatry should be gained during training. Opportunities will naturally be greater in district general hospital units than in psychiatric hospitals.

All trainees should receive adequate supervised experience in the assessment and management of parasuicide. Other valuable experience might include eating disorders, neuropsychiatry, pregnancy-related disorders, etc.

2.6.6. Mental Handicap

There should be an exposure sufficient to give the trainee an awareness of the nature and scope of the problems. The emphasis should be on psychiatric and psychological treatment rather than on basic physical care.

Between three and six months full-time clinical experience or its equivalent would be desirable. Experience in the community such as in clinics, hostels and homes should be included.

2.6.7 Old Age Psychiatry

Particular importance is attached to experience in this area because of the increasing number of elderly people in the population and the high incidence of mental disorder in this group.

The Old Age Psychiatry should constitute a separate attachment within the rotational training scheme where the local arrangements permit, e.g. if there is a consultant with a special responsibility in the psychiatry of old age and/or a psychogeriatric assessment unit.

Trainees should gain experience in the acute and functional mental disorders of the elderly, rather than being exposed solely to patients with dementia.

2.6.8. Rehabilitation

Attachment to a rehabilitation team, with particular emphasis on the care of patients with severe chronic disability, is to be recommended. Such experience should involve not only inpatients, but day care, including day centres and liaison with hostels, supervised lodgings and sheltered workshops.

2.6.9. Research

There should be opportunities for trainees to undertake or participate in a piece of supervised research. This is always easier to achieve in a setting where consultants are actively involved in research projects.

For research experience to be recognized in professional training, individual application to the Education Committee for vetting is required. A maximum of six months of experience may be approved as part of the six years of supervised training.

2.6.10. Psychotherapy

All junior trainees should have an adequate exposure and supervised experience in psychotherapy with the following basic requirements in order to be eligible to take the FHKCPsych Fellowship Examination. The main purpose of the basic training is to enhance their interview skills, heighten their emotional awareness of therapeutic relationship, and to be able to deliver basic psychological interventions for patients with relatively less complex disorders, as well as to be able to refer appropriately for patients with complex needs to expert psychotherapy care.

Basic Requirement for Psychotherapy Training for trainees (applicable to all junior trainees entered into the training scheme on or after 1 July 2010)

- Attend a minimum of thirty case based discussion group sessions before applying Part III fellowship examination. Each case-based discussion should be led by a psychotherapy trainer or his/her delegated psychotherapy supervisor. In the case-based discussion, trainees are expected to take up an active role of presenting patients

that they encounter in daily practice with diagnostic and management issues. The patients identified for discussion can be patients currently receiving psychotherapy under supervision or patients encountered during daily in-patient or out-patient services. Issues raised up would be considered as of benefit to the patients and the trainees alike, when being viewed from a psychological perspective. Peer supervision of cases under psychotherapy is also accepted as an alternative form of case-based discussion. The trainees are expected to record their attendance of such activity in each training centre on a training log of case-based discussions, certified by a psychotherapy trainer of the centre. Training log sheet is available on College website since July 2014. The psychotherapy trainer should also keep a separate record of the attendances for audit purpose.

- Undertake at least two psychotherapy cases, preferably in two modalities, before applying for the Part III Fellowship Examination. One should be short-term individual case (**of at least ten sessions with duration of up to six months**) and another should be a long-term individual case (at **least twenty five sessions with a duration of at least twelve months**). It is expected that the patient selected for short-term psychotherapy suffers from relatively simple Axis-1 disorder while the one for long-term psychotherapy suffers from psychiatric disorders with complex needs. The trainees are strongly advised to seek support from their psychotherapy trainers or the delegated psychotherapy supervisors to identify suitable patients for psychotherapy. Upon completion of the case or the recommendation of the psychotherapy trainer, a case report of not less than two thousand words should be submitted to the psychotherapy trainer for approval and endorsement (see appendix 1 for a short-case CBT sample). After completion of the short-term and long-term psychotherapy cases, the trainer would then complete a rating form for each case, stating that the trainee has fulfilled the requirement before applying for Part III exam(see appendix 2 for the rating form)
- Some experience in group, couple or family therapy is preferred in addition to individual psychotherapy
- Upon application to the Board of Examiners for part III fellowship exam, the senior trainees must submit certified true copies of the attendance log sheet of the case-based discussion group and the certified true copies of rating forms of the two psychotherapy cases signed by the psychotherapy trainer (or equivalent if there is none in the psychotherapy training station in the cluster).

2.6.11 Electroconvulsive Therapy (ECT)

(applicable to all junior trainees entered into the training scheme on or after 1 July 2018)

1. Before applying for the Part II Fellowship Examination, the trainees should have at least one observed ECT practice and three supervised ECT practices*
2. Before applying for the Part III Fellowship Examination, the trainees should have at least three independent ECT practices.

*(N.B.: *Trainers should ensure that their trainees have adequate theoretical knowledge before delivering ECT)*

2.7. Selection of Trainees

The **Education Appointment Committee** would select suitable candidates into the training scheme. The Committee will determine eligibility of a trainee to continue training within the scheme with a fair mechanism.

A medical practitioner who has been registered with the Medical Council of Hong Kong, has been accepted into a training scheme and has been appointed to a recognised training post for general professional training in psychiatry as a junior trainee should apply to register with the College as an inceptor.

A medical practitioner who has been registered with the Medical Council of Hong Kong, has been accepted into a training scheme and has been appointed to a recognised training post for higher professional training in psychiatry as a senior trainee should apply to register with the College as a member.

2.8. Organisation and Administration of Trainees

Trainees should form a **trainee committee** to discuss the training programme and to nominate representatives to join in the Education Committee and other committees of the College.

2.9. Assessment of Trainees

Trainee's progress should be regularly assessed by trainers and tutors. Feedback to the trainee informally at any time during the period of attachment is desirable, but formal feedback at the mid-point and at the end of a rotational placement is mandatory. The College's Training Log Book should be used.

Assessment forms in general cover the following points.

- ability in history filing, formulation and oral and written case presentation
- therapeutic skills and judgement
- relationship with patients and their relatives and with colleagues
- theoretical knowledge of psychiatry
- knowledge of and skill in general medicine at a level appropriate to a general medical practitioner
- initiative, reliability, self-reliance and administrative ability
- communicative skills

Trainee's views of the training post should also be obtained.

2.10. About Tutors and Trainers

Tutors and Trainers are experienced Fellows of the College or a practising specialist in Psychiatry in Hong Kong. They would spend time regularly to supervise the trainees.

Supervision and instruction of trainees make considerable demand on the time of the tutors/ trainers. A trainer should supervise at most three trainees at one time (one junior & two senior trainees or one senior & two junior trainees, irrespective of full-time or part-time training). Each trainer is recommended to have at least one trainee under his or her supervision and training.

2.11. Types of Teaching

Each scheme should provide a variety of teaching experiences. The following list is considered as a guide and should not be regarded as exhaustive:

2.12. Direct Supervision

Probably the single most important ingredient of clinical training is regular direct supervision, either individually or in a small group, by the trainers. Such supervision should occur at least weekly.

In Out-Patients Department, new patients as well as follow-up patients should be seen and adequately presented to the trainer, preferably in a multi-professional setting.

2.13. Ward Round

Ward rounds (at least weekly), where other disciplines will also be involved.

2.14. Case Conference

Case conferences where the trainee has an opportunity to present and discuss a patient (either directly or using video tapes) with other specialists or visiting teachers regularly.

2.15. Interview Skill Tutoring

Teaching of interviewing skills. This is best done as special teaching occasions, with other trainees, early in training, using video tapes, in addition to teaching under 1-3 above.

2.16. Journal Club

Journal clubs, where trainees have the opportunity to review a piece of published research, with discussion chaired by a specialist (weekly, for not less than twenty weeks in a year). It is important that trainers are regular attendees at the case conferences and journal club.

2.17. Academic Course

Systematic course of lectures and/or seminars covering basic sciences and clinical subjects related to general psychiatric training.

Teaching in related subjects. Although basic sciences may be covered by a university-based course, teaching by local professionals is highly desirable. These should include clinical psychologists, social workers, nurses, occupational therapists and health administrators.

2.18. Management Training

Familiarity with management issues is increasingly important for psychiatric trainees aspiring to become specialists.

Trainees should have some opportunity for involvement in administration (perhaps of the training scheme itself and also at ward or unit level). Opportunities for learning about management should ideally be available.

2.19. Medical Ethics

Medical ethics should be an important part of teaching.

2.20. Special Situation

Relationships between University Teaching Hospitals and other Psychiatric Hospitals and Units

A training scheme should have some liaison with a local university department of psychiatry. In some cases, university teaching hospitals lack certain types of clinical experience and a mutually complementary rotation can be set up. Ideally, all trainees should have an opportunity of working in a university teaching hospital.

All training centres should see themselves as "teaching centres" and should not rely on a clinical rotation to a university teaching hospital as their only 'academic input'.

University departments, teaching hospitals, and regional centres should be able to offer the following to all schemes:

- courses of instruction on a day or half-day release basis

- specialised clinical supervision, e.g. in psychotherapy
- supervision and advice on research projects
- tutors who will visit local schemes on a regular basis for teaching occasions, such as case conferences and journal clubs

2.21. Other Facilities Required

2.21.1. Medical Facilities

Patients must have access to good medical and surgical facilities and trainees must have the opportunity to liaise with appropriate specialists and laboratory-based staff when investigating and treating physical illnesses of patients under their care.

2.21.2. Library Facilities

All trainees and trainers must have easy access to a library providing adequate services. The library should contain an appropriate stock of books and journals (physical or electronic), access to internet, as well as offering loans, inter-library loans, photocopying and other information services.

While such facilities may be offered by larger libraries in the vicinity, it is essential that basic services should be provided on site, i.e. a core collection, loans (including inter-library) and a general information service. Use of other libraries is likely to be arranged via the librarian. Formal agreements must be entered into to provide this back-up, including reciprocity.

2.21.3. Consulting Rooms, Meeting Rooms and Offices

An essential requirement is the provision of an adequate number of rooms in a treatment area where patients and relatives can be interviewed safely, in comfort and with privacy. These must be provided both on the wards and in out-patient departments. Such rooms are often unavailable on general medical or surgical wards and special efforts need to be made to provide for privacy and confidentiality when doing "liaison work".

At least one adequately sized meeting room is essential, large enough for all the staff working in the unit. There should be adequate accommodation for seating people in comfort, to facilitate the holding of team meetings, case conferences and similar activities. A large psychiatric hospital may need several of these rooms. It should not be necessary to use any of the patient's accommodation for this purpose.

Ideally, every trainee should be provided with his or her personal office. Every trainer requires an office. Adequate secretarial support is also essential

2.21.4. Accommodation for Organised Postgraduate Activities

Lecture room

This should be large enough to accommodate all the psychiatric medical staff together with such numbers of doctors in other specialities and non-medical staff as may be expected to attend meetings.

The lecture room should be designed so as to permit the ready use of computer, slide, cine and LCD projectors, and any other audio-visual equipment considered necessary. It should have facilities for the safe storage of this equipment.

Seminar room

This should be less formal in character and suitable for group discussions involving up to sixteen persons. More than one seminar room may be necessary.

Where it is necessary to share the use of lecture and seminar rooms with other specialties and disciplines the numbers of those sharing should not be so great in relation to the number of rooms available as to make it difficult to arrange meetings, or impossible to do so unless rooms are reserved long in advance.

Video facilities

With the requirements for training in interview skills for Part I Examination, there should be facilities for using video equipment for such training.

Ideally a separate studio should be available but otherwise facilities in a seminar room or lecture room would be acceptable.

2.22. Medical Audit/Quality Assurance

Medical audit is required as a compulsory part of the work of any district in which training in psychiatry is taking place. Trainee should participate in some audit project experience during the training period. This should include surveillance of the standards of case notes, assessment of the quality of patient care, regular audit meetings which should give detailed consideration to untoward events taking place within the service (e.g. suicide and other deaths in hospitals) and case conferences for each consultant in the clinical service.

Continuing medical education for trainers should also be seen as part of the process of audit within approved hospitals.

2.23. Case Record Standard

In a clinical discipline, the main vehicle of learning is the detailed study of individual patients. The results of this enquiry are recorded in the case records, which serve as a channel of communication between professionals about the diagnosis and treatment of the patient concerned.

The case records are a valuable data source for psychiatric research, may be subpoenaed by the courts and may be used for clinical audit. For all these reasons, therefore, the quality of the records must be high on accredited teaching units, and their standard is one of the criteria by which these units may be judged.

2.24. The Organisation of the Record

There are several acceptable ways of organising a case record, including:

Organisation by successive admissions, with all information relevant to that admission (correspondence, nursing observations, investigations, reports by social workers, psychologists and occupational therapists, and outpatient follow-up notes), compiled in the same compartment as the inpatient medical notes.

Organisation by data source, with separate compartments for inpatient admissions, outpatient care, nursing observations, correspondence and investigations.

Organisation as a consecutive record, all sources being compiled in chronological sequence.

Organisation in problem-orientated form.

The College would not wish to express a preference for one method of organisation, but rather to stipulate the elements which should always be present in a case record of teaching standards.

Case records should be typed or written legibly.

2.25. The Contents of Case Records of Teaching Standard

The reason of referral (or admission) should be stated with an account of the circumstances and events leading to it.

The clinical state should be documented, by an exploration of symptoms and an examination of the physical and mental state.

The exploration of symptoms includes verbatim statements made by the patient about the main complaints together with the answers to clarifying questions about these and related symptoms. It also includes an account of the development of the illness and of the psychiatric history.

The mental state examination includes:

An exploration of the patient's preoccupation and concerns, including his/her self-esteem (self-image), hopes, grieves and fears;

The review of major psychiatric symptoms such as morbid ideas (content and form), perceptual anomalies and mood disorders;

Observations about appearance, behaviour, affect, speech and rapport with the interviewer;

The testing of cognitive functions including orientation, intelligence, concentration and memory and (in appropriate patients) neuropsychiatric testing.

The patient's account of the personal history and clinical state is amplified by corroborative accounts especially from relatives, carers, nursing staff (for in-patients), and other members of the multi-disciplinary teams, who have observed behaviour in a variety of settings. If the patient has been in psychiatric treatment before, the case records are obtained, studied and summarized.

There should be an account of the personal history, including the family background, childhood and schooling, work record, psychosexual and marital history, health, lifestyle (including deviant behaviour) and present circumstances. If this has already been explored at previous referrals, it is not always necessary to start afresh at the beginning. It may be acceptable and even preferable to update the earlier account by further clarification and exploration of recent events.

The personal history pays particular attention to the nature and quality of relationships, especially with the family of origin, partner and children.

There must be a consideration by the trainee of diagnosis (assessment), including differential diagnosis, and treatment (management). The diagnosis, should not be limited to the clinical state, but should include an assessment of personality and social circumstances, with an attempt to clarify the interaction of past and present factors in producing the recent situation.

In the best teaching units, this discussion will often include the results of reading in the library about the salient features of the patient's illness.

The discussion of management should include a plan of further investigation if necessary, an account of the style and role of psychotherapy and social treatment as well as pharmaceutical treatment, with details of the part to be played by each member of the team.

The patient's progress in hospital, outpatients or home treatment is documented by frequent, legible and concise notes. Changes in clinical state and treatment plan are clearly recorded.

At the time of discharge, a note is made of the clinical state (comparing it with that present at the height of the episode), and of recommendations for future treatment.

Major episodes, whether treated in hospital or at home, are drawn together by typewritten summary for ease of reference. These summaries may be organised episode by episode or in the form of an overall summary of the whole course of the illness. For patients treated in the outpatient clinic, letters to the general practitioner can serve as summaries.

3. APPOINTMENT OF TUTORS AND TRAINERS

3.1. Tutor

A Tutor is an individual identified in the training unit as the person responsible for postgraduate psychiatric training and education and who is in regular weekly contact with the trainees. This Tutor is responsible for organising day release course for trainees.

3.2. Trainer

A Trainer is an individual who is the direct supervisor of the trainees under his/her supervision. A Trainer is expected to have frequent regular contact with the trainees.

3.3. Criteria for Appointment

3.3.1. Qualification

Both tutors and trainers must be medically qualified. Trainer must be a practicing specialist in Psychiatry, leading an accredited functionally independent unit and having at least 3-year post Fellowship experience or holding an academic position of associate professor or above.

3.3.2. Mode of Appointment

The appointment should be made with the advice and agreement among the colleagues of tutors of a particular training scheme/ unit. The training unit should submit the names of Tutors and Trainers to the Education Committee for recognition.

3.4. Sessional Time

There should be local recognition of the need for each tutor/trainer to devote a minimum of one session per week to his training duties.

The time which will need to be devoted to various activities will vary considerably with the number of trainees for whom the tutor is responsible. The College in its assessment will take account of the time devoted to administration (including the preparation of reports and discussions of trainees' progress with other trainers), and to face-to-face teaching and counselling of individual trainees.

3.5. Activities

In applying for Appointment, tutors should be able to demonstrate that they are operating active programmes of teaching in their training unit including Case Conferences, Seminars and Lecturers, Journal Clubs and Research Review Meetings.

They should keep abreast of educational technology and endeavour to provide appropriate audio-visual aids. Where local resources are inadequate, it should be possible to arrange appropriate teaching or experience for trainees elsewhere. In the case of specialty tutors and academic organisers, it will be necessary for the individual to describe the activities and responsibilities arising from that role alone.

3.6. Communication with Colleagues

To merit Recognition the tutor should meet regularly with other psychiatric tutors, specialty tutors and advisers in his area or region as well as senior members of the nearest academic Department of Psychiatry. There should be regular contact with tutors in other disciplines, including those involved in vocational training schemes for general practice.

3.7. Procedure for Appointment

Application for appointment as a Tutor or Trainer should be addressed to the Honorary Secretary of the Education Committee.

4. REGISTRATION OF PSYCHIATRIC TRAINEE

Application for registration as a trainee in professional education and training in psychiatry should be addressed to the Honorary Secretary of the Education Committee on the recommendation of a recognized psychiatric tutor.

5. REQUIREMENT FOR ENTRY TO THE FHKAM (PSYCHIATRY) EXAMINATION PART I

5.1. Medical Registration

Candidates should be registered with the Medical Council of Hong Kong.

5.2 Basic Requirements

5.2.1. Duration of Training

A minimum of one year's full-time post-registration experience in an approved psychiatric training scheme in Hong Kong is required. This training should be either twelve months in General Adult Psychiatry or six months in General Adult Psychiatry and six months in Old Age Psychiatry.

Only full time post-registration training in a psychiatric scheme approved by the Hong Kong College of Psychiatrists would be considered.

The minimum duration of any one appointment should generally not be less than six months.

5.2.2. Requirements for Academic Training

Training for the Part I Examination should consist of supervised practical clinical experience in psychiatry and

- Attend 70% of the Central Academic Course, and
- Satisfactorily complete three case books (as endorsed by accredited trainers).

5.3. Application

Candidates must furnish evidence on the prescribed forms to show that they have obtained not less than one year's full-time post-registration training in an approved psychiatric scheme in Hong Kong either twelve months in General Adult Psychiatry or six months of General Adult Psychiatry and six months of Old Age Psychiatry.

A junior trainee sitting the Part I examination must fulfill all requirements of training experience as set at the time when he/she applies for the examination.

Service residents are not eligible to sit for the Part I Examination.

5.4. Number of Attempts and Time Allowed for Attempts

There is no upper limit as to the number of attempts for Part I examination.

6. REQUIREMENTS FOR ENTRY TO THE FHKAM (PSYCHIATRY) INTERMEDIATE (PART II) EXAMINATION

6.1. Medical Registration

Candidates should be registered with the Medical Council of Hong Kong.

6.2. Basic Requirements

6.2.1. Basic Qualifications

Candidates must have passed the Part I Examination or hold an equivalent qualification approved by the College to proceed to the Intermediate Examination.

6.2.2. Duration of Training

The Intermediate Examination should be taken normally after three years (must not be less than twenty nine months) full-time experience in post-registration training approved by the College.

Attachment in General Adult Psychiatry of a minimum of eighteen months duration is strongly recommended for the first three years of professional training. However, in the event of difficulty of fulfilling this requirement within the said period, trainees are still required to have a minimum duration of General Adult Psychiatry of twelve months in the first three years of general professional training. The remaining six months of General Adult Psychiatry training must be made up in the higher professional training period.

Twelve months of General Adult Psychiatry is mandatory in the first three years of professional training.

The minimum duration of any one appointment should generally not be less than six months.

6.2.3. Requirements for Academic Training

Training for the Part II Examination should consist of supervised practical clinical experience in psychiatry and

- Attend 70% of the Central Academic Course, and
- Satisfactorily complete five casebooks (as endorsed by accredited trainers). Candidate should have completed total seven casebooks by the end of General Professional Training, and
- Fulfil at least one observed ECT practice and three supervised ECT practices.

6.3. Application

Candidates must furnish evidence on the prescribed forms to show that they have had not less than twenty nine months of full-time post-registration training in an approved psychiatric scheme in Hong Kong.

Some subspecialty experience is highly desirable. In each subspecialty such as Child Psychiatry, Mental Handicap, Old Age Psychiatry, Forensic Psychiatry or Psychotherapy, not more than twelve months full-time training will be accepted towards this three year period of general professional training.

A junior trainee sitting the Part II examination must fulfill all requirements of training experience as set at the time when he/she applies for the examination.

Service residents are not eligible to sit for the Part II Examination.

6.4. Number of Attempts

There is no upper limit as to the number of attempts for Part II examination

7. REQUIREMENT FOR ENTRY TO THE FHKAM (PSYCHIATRY) EXIT (PART III) EXAMINATION

7.1. Medical Registration

Candidates should be registered with the Medical Council of Hong Kong.

7.2. Basic Requirements

Candidates who may apply to sit for Exit Examination should fulfil the following basic requirements:

7.2.1. Basic Qualifications

The candidate should have passed the Intermediate Examination or hold an equivalent qualification approved by the College.

7.2.2. Duration of Training and Experience

The candidates may attempt the oral part of the EXIT examination after fulfilling the following requirements.

A trainee should have completed at least eighteen months of General Adult Psychiatric training, at least six months MUST be involved in the management of patients admitted to hospital under Part III Cap 136, Mental Health Ordinance, Hong Kong.

A trainee should have received \geq three years of General Professional Training, passed intermediate (Part II) examination, and completed \geq twenty nine months of higher professional training, or

A trainee should have passed an Intermediate (Part II) examination. If the duration of General Professional Training is $<$ thirty six months, he/she should make up the remaining requirement for General Professional Training in the capacity of Higher Professional Training to be eligible for the first attempt of oral examination of the EXIT examination. The minimum duration of higher professional training required for first attempt of oral examination of the EXIT examination would then be twenty nine months plus the remaining requirement to fulfil three years General Professional Training.

After successfully passed the oral examination, candidates should submit a final version of the dissertation for completion of the EXIT examination at the end of the higher professional training.

Fellowship could only be granted if a trainee passed all requirements of the EXIT examination and has completed \geq six years of professional training (at least thirty six months should be in the capacity as a higher trainee).

For granting of fellowship, in these six years, the candidates should have at least:

- A minimum of eighteen months' experience in General Adult Psychiatry of which six months MUST be spent in the management of patients admitted the hospital under Part III Cap 136, Mental Health Ordinance, Hong Kong and
- A minimum of full time training of six months' duration or its equivalent in three of the other subspecialties* apart from General Adult Psychiatry and
- A minimum of eighteen months duration of attachment in a subspecialty in the capacity of a senior trainee. The eighteen months attachment in a subspecialty as a senior trainee can be taken as one of the four subspecialty experiences required.

7.2.3. Requirements for Academic Training and Application

- Obtained at least fifteen points per year in the College approved Continuous Medical Education (CME) programs during the period as Senior Trainee, and
- Submitted a satisfactory yearly Evidence-Based Review to Tutor(s) and Trainer(s), and
- Attend a minimum of thirty psychotherapy case-based discussion group sessions, and
- Undertake two psychotherapy cases, preferably in two different modalities. One should be short-term individual case (at least ten sessions with duration of up to six months) and the another should be a long-term individual case (at least twenty five sessions with a duration of at least twelve months), and
- Fulfil 70% of Central Academic Course (CAC) protected time, and
- Fulfil at least three independent ECT practice, and
- Prepared a dissertation on a subject related to the psychiatry which is accepted by the College.

7.3. Form of Examination

The Exit Examination is in the form of an oral examination in front of a panel of examiners.

7.4. Number of Attempts

7.4.1. First Attempt While in Training Scheme

The candidates may have their first attempt of Exit Examination after fulfilling the basic requirements outlined above.

7.4.2. First Attempt While Not in Training Scheme

A candidate can choose to delay his/ her examination after completion of the basic requirement and opt not to stay in the Training Scheme. However, he/ she can only opt out of the Training Scheme for a maximum of three year (out-scheme) before making the first attempt.

7.4.3. Second and Further Attempts While Not in Training Scheme

A candidate may sit for his/ her second and further attempts in the examination during the Training Scheme opt-out period, However, in that opt-out period, the candidate should still be spending more than half time in direct clinical care of patients, fulfils continuing medical education and evidence-based case review requirements as for senior trainees listed above.

7.5. Senior Extended Training

If a candidate has left the Training Scheme for more than three years and would like to sit for the examination, he/she should re-enter higher psychiatric Training Scheme as “Senior Extended Trainee” for a minimum of one year full-time or its equivalent training before attempt the Part III Examination. The equivalent Senior Extended Training concerned should be completed within two years. During the senior extended training, the candidate should still fulfil continuing medical education and evidence-based case review requirements as for senior trainees listed above.

7.6. Further Opt-out

Candidates may opt-out of the Training Scheme (out-scheme) for a maximum of three years after completion of the Senior Extended Training.

A candidate who has a total six years continuous lapse in training should apply to the Education Appointment Committee for renewal of his/ her eligibility as well as re-appointment in higher psychiatric training as for an aspiring Senior Trainee.

7.7. Special Consideration for EXIT Assessment

Experienced psychiatrists may apply for special consideration of EXIT assessment. Enquiries and Application for eligibility assessment should be addressed to the Honorary Secretary of the Hong Kong College of Psychiatrists.

7.8. Part-time Senior Trainee

The eligibility criteria for part-time senior trainee to apply for Part III Examination should be the same as that of full-time trainee.

*Subspecialty refers to experience required for training purposes. There is no subspecialty specialist recognition in the Hong Kong College of Psychiatrists at the time of preparation of this handbook.

Amended by Education Committee in March 2006

Endorsed by Hong Kong Academy of Medicine in April 2006

Amended by Education Committee in April 2008

Endorsed by Hong Kong Academy of Medicine in September 2008

Amended by Education Committee on 2 January 2013

Endorsed by Hong Kong Academy of Medicine on 19 February 2013

Amended by Education Committee on 4 December 2015

Endorsed by Hong Kong Academy of Medicine on 12 January 2016

Amended by Education Committee on 25 June 2018

Endorsed by Hong Kong Academy of Medicine on 10 July 2018

8. APPENDICES

Appendix 1

TITLE:
Cognitive Behavioural Therapy
Short Case

CANDIDATE:
XXX

SUPERVISOR:
Dr. Roger Ng

Total word count:
2709

1. INTRODUCTION TO PATIENT (The personal information is substantially altered to protect anonymity of the patient)

1.1 Background Information

Madam Kwong is a 45 year old lady. She works as a manager in a product company. She is married with 2 children. She lives with her family in a private flat in Tuen Mun.

Family history and early development

Madam Kwong was born in a peasant family in Hong Kong. She was the youngest of 3 children. Her father used to be a seaman and was seldom at home. He developed mental problem since patient was 6 years old and was being moved to another abode. She had scarce communication with her father until his death 6 years ago. Madam Kwong's mother supported her family by working as a farmer, whose work was busy and had limited time for her at home. Madam Kwong spent most time on her own since young as her elder brother and sister were already in work and school respectively. Madam Kwong suffered from some skin problem in childhood which often attracted curious gazes from other people. She thus enjoyed playing alone rather than with friends in the field, in order not to attract attention. She recalled there were no authoritative figures in her life since young and she had to deal with most matters on her own, including dealing with school matters and choosing her secondary school.

Educational and vocational history

Madam Kwong studied in a rural primary school in the New Territories. She then studied in a rather renowned secondary school. Her academic result was poor since primary school as her family did not pay much emphasis on studying. She was frequently scolded by her secondary school teachers for being 'lazy' and 'stupid'. She also had concern about her skin problem and felt her classmates were seeing her as a monster. She commented that her secondary school life was more unhappy than happy. She had great academic improvements during her high school years with help of her peers and was able to achieve satisfactory results in the HKCEE. However she left school for financial reason. She worked in fast food shops and factories initially and continued her study at night. Gradually she completed a Degree course. She completed a Master programme in Management.

Madam Kwong was diligent in work and had been promoted repeatedly. However she often believes she does not deserve to be promoted as she believes she does not have goals on her career. She changed to her current company 8 years ago after she was promoted in her previous company. She found it very stressful after the promotion and she preferred a lower ranking job with lower salary in the current company. She is now working in a managerial position in an international printing company whose work requires occasional business trips.

Medical history

Madam Kwong described herself as someone who got sick easily. She mentioned she had a discolouring skin problem since childhood. Her family had brought her to various doctors

and even temples for treatment. The skin problem had contributed to her avoidance of meeting other children, in fear that she would be laughed at. She gradually grew out of her skin problem in her late teens. In recent 10 years, she had been troubled by problems like episodic swelling of limbs and face. She had sought help in various medical practitioners, Chinese medicine practitioners and even treatment by QiGong. No exact diagnosis was told though some of the doctors told her it may be related to autoimmune problems. She personally attributes it to be due to problems in 'lymph flow'. Madam Kwong continues to seek help from different conventional and unconventional bodies for her problem. She is currently not on any medical treatments. Nonetheless Madam Kwong believes she has an unknown illness and lest the exact cause be found there will be risks of having serious illness in the future.

Madam Kwong is a non-smoker and non-drinker. She has no history of substance abuse.

Relationship history

Madam Kwong had 2 previous courtships before her marriage. She was married in 1993 after 4 year of dating with an ex-colleague of hers. She described her husband as a 'smart and happy person'. They have 2 children, aged 14 and 10. She has few common interests with her husband and children. She revealed she had never been particularly fond of children and it was her husband's idea to raise children. Nonetheless she described herself as a responsible mother.

View to self, others and the world

Madam Kwong described herself as 'stubborn, selfish and introverted'. She believes she is inferior to most of others, including her husband and her children, and the only way to gain recognition is by studying. She enjoyed studying in different courses in order to meet new people. However she does not keep friendships. She believes it was because she was not a 'good' person and often offends others inadvertently. She believed having emotion or feelings is something bad as it often causes fluctuations in her mood. She also believe it will inconvenience others if her emotions are shown.

Madam Kwong reported difficulties in trusting others. Regarding her childhood experience, she believed the world did not give her what she deserved. Throughout the years she had been coping by avoiding thoughts or memories about her early years. She believed most of the things can be controlled. She has no religion beliefs. After the accident, her view to the world became more pessimistic. She believed not everything can be predicted and controlled and the world is unsafe.

As mentioned above, Madam Kwong had negative view towards herself since long time ago. She felt she had become a better person after she got married as she was influenced by her husband to be more outgoing and considerate. She believe she had a tendency to become her 'previous' self which was 'bad' after the accident.

1.2 Presenting Problem

Madam Kwong first presented to our clinic June 2009. She was referred from private doctor for 'post traumatic phobic attacks'. Madam Kwong suffered from a road traffic accident

March 2009 when she was knocked down by a car from behind while she was walking on the pavement. She sustained soft tissue injury on her right foot. No fracture was found and she was discharged home from the hospital on the same day. She has persistent pain over her right foot and she needed wheelchair while going out in the first 2 months post injury. She had visited various medical practitioners and was told her injury was largely healed. Aside from the injury Madam Kwong was particularly enraged by the inaccurate depiction of the incident by the media, describing her as careless. She planned to file a law suit against the driver and the car owner.

Madam Kwong developed fear towards traffic afterwards, especially when she was crossing roads or walking between cars. She had hyperarousal responses towards sudden loud noises. She suffered from frequent intrusions and nightmares related to the accident. She developed various avoidant behaviours, for example going to work on foot instead of by MTR to avoid the crowd and noises. She took extra precaution in looking in all directions when walking, thus slowing down her speed of walking considerably. She had avoided driving. She felt distressed by the above symptoms.

1.3 Diagnosis

Madam Kwong was diagnosed to have Post Traumatic Stress Disorder.

1.4 Standardised and Personalised Quantitative Outcome Measures

Impact of events scale: Intrusions – 11

Arousal- 10

Hypervigilance – 16

Total – 37

BHS: 10

BDI: 20

BAI: 19

1.5 Previous Treatments and Expectations of CBT

Madam Kwong has no past psychiatric history and she has not received any psychological treatments in the past. She expected CBT would give her direct advices to deal with the distressing symptoms of PTSD. Her aim of the treatment was improvements of the symptoms and to be able to return to her previous self.

2. CASE CONCEPTUALISATION

2.1 Case formulation

Madam Kwong's childhood hardship had predisposed her to her untrusting nature and her low self-esteem. Her habitual avoidance of emotion, rooted from her neglected childhood, had probably contributed to her resilience during that period when she face ridicules in social settings and allowed her to concentrate and strive at work. She gained the sense of control through her achievements. However her low self-esteem, untrusting attitude and avoidance of emotion persisted through adulthood and had resulted in interpersonal

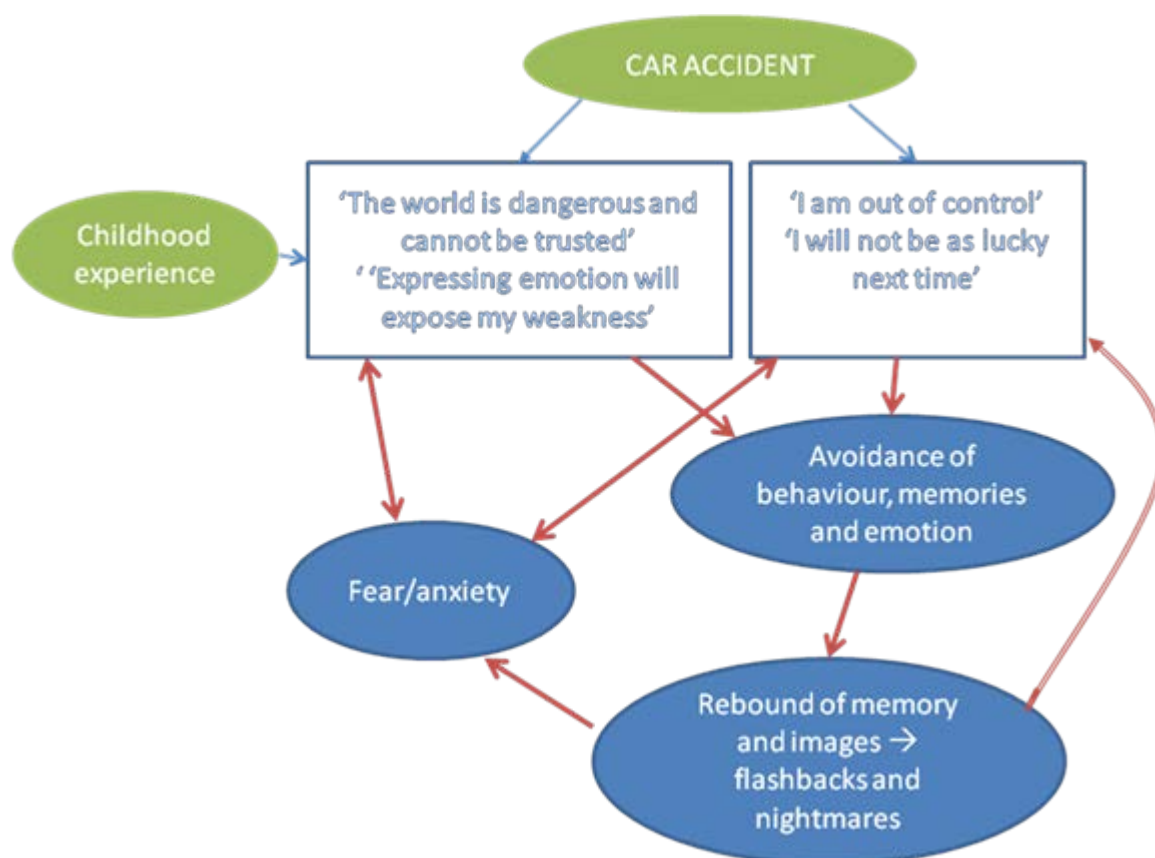
difficulties which she faced, again, with avoidance. Her frustration was intellectualized and had manifested as her multiple physical problems.

Her current symptoms were precipitated by the traffic accident which happened on the supposedly safe pavement. Despite the fact that she was not severely injured, the incident had triggered her distrust towards the world. The accident also inevitably aroused her emotions which she sees as shameful and 'bad'. The sense of being out-of-control returned. The usual avoidance and suppression she had practiced all along had accentuated her flashbacks and nightmares, resulting in more frustration and anxiety. In fact her avoidance had perpetuated the PTSD symptoms and reinforced her dysfunctional beliefs.

2.2 Problematic beliefs and assumptions

- Selective attention
- Over-accommodation resulted in all-or-none thinking
- 'Expression of emotion is something bad and would express my weakness which would lead one to be looked down upon and be rejected by others.'
- 'inability to control my emotion equals to loss of control to self'
- 'I was lucky this time and I will not be as lucky in the future. I will not survive future accidents'
- 'I am a selfish person thus I have no friends.'

2.3 Case conceptualization flow chart



3. COURSE OF THERAPY

3.1 Overview of aims and guiding strategy

In Madam Kwong's view she hope after the therapy she could return to her previous self. The targets that she set during the initial stage of therapy includes being able to cross the road without fear, able to face sudden noises without hypervigilance, and to be able to relate to the accident without negative emotions.

Throughout the initial assessment, it was noted patient had a long practiced pattern of avoidance of emotion which could hinder the progress of her recovery on the symptoms of PTSD. Thus the understanding of the role of emotion and the recognition and experiences of emotions were added as additional aims of therapy.

The principles of trauma-focused cognitive behavioural therapy were discussed.

3.2 Early sessions (session 1-3)

Initial assessments were performed by means of history taking and the use of standardized measures (IES, BDS, BHS, BAI). Patient's view on herself, others and the world explored. The principles of trauma-focused cognitive behavioural therapy were discussed. A schedule of 12-14 sessions was agreed upon.

During the history taking patient apparently showed no difficulty in talking about the accident. It was found later that it was because she had deliberately avoided any emotions when recalling the incident. Her prominent PTSD symptoms were revealed through the high score of IES.

Symptoms of PTSD and the role of avoidance in maintaining the symptoms discussed. The importance of assignments explained. Patient was given the Impact Statement as her first assignment at the end of session 3.

3.3 Mid-phase of the treatment (session 4-9)

Session 4 was a turning point in the course of therapy. During the session patient had a catastrophic reaction towards her loss of the assignment. Patient also expressed stress towards coming to sessions, casting doubt on whether she would continue with therapy. It was then evident patient had issues on expressing and experiencing her emotion and if the issues were not dealt with they could hinder the course of treatment. Thus the topic of emotion was emphasized in the subsequent sessions. Importance and functions of emotions was illustrated with various metaphors. Experiencing emotions, especially negative ones, were encouraged during sessions. The aim of therapy emphasized and efforts were made to realign the therapeutic relationship.

Dysfunctional thought records were given as assignments after examples were done during sessions. However patient showed difficulty in completing the record, partly related to her difficulty in naming emotions. Thus the assignment was modified with a list of possible emotions added on the worksheet. Exercise like role-playing and recognizing various emotions from pictures were practised to illustrate the possibility of experiencing multiple emotions for a single incident.

Another piece of assignment was to encourage patient to tape record the sessions and to listen to the record after the session ends. It was intended to act as a reminder on the key points discussed during the session and an opportunity to experience the related emotions.

Throughout the sessions patient had not been compliant to the assignments. She had avoided the assignments due to the anxiety provoked during the process. The issue was dealt with by doing the assignment together in session. This also allowed real-time evaluation of the emotion aroused.

3.4 Final treatment phase – (session 10-14)

Despite the noncompliance on assignments the symptoms of PTSD had gradually improved. The quantitative outcome measure scores on session 10 showed improvements in all measures (IES 19, BHS 5, BAI 10, BDI 11). Patient had self-initiated driving trials with partial success. Emphasis was given on issue of risks and opportunities and its relevance in managing her safety behaviours. Possible situations that may arouse her anxiety in the future were suggested and ways of coping discussed.

3.5 Process issues

During the early stage of treatment there were times when I became worried about patient quitting therapy prematurely. At that time patient had commented the therapy was not useful and she had not improved. Apparently the negative emotion patient had expressed during the session had also affected my attitude towards the case, and I looked at the matter in an all-or-none manner as well. The problem gradually solved after we tried to see it as a learning opportunity.

4. OUTCOME

4.1 Post-treatment problem ratings

Her hyperarousal and intrusion symptoms had much improved. She still practiced some safety behaviours like looking around when walking on street. She is willing to try to drive on her own after therapy.

4.2 Scores on standardised measures

IES: I 5, A 7, H 7, Total 19

BHS 5

BAI 10

BDI 11

4.3 Patient's view of her progress

Patient believed she had improvement when compared to initial stage of therapy. Although she believed she has not yet returned to her previous level, she had accepted the residual symptoms as a reminder of what she had learnt from the accident and the subsequent treatments. She also showed hopes towards further improvement in the future.

5. DISCUSSION/ REVIEW

5.1 My own learning

The case had given me the opportunity to conduct cognitive behavioural therapy in PTSD patients. I had a more in depth understanding in the cognitive model of PTSD. I understood the importance of therapeutic alliance and how patient's attitude can affect my own schema and the progress of therapy. I appreciate every patient is a unique individual and different strategies are needed for their different needs.

5.2 Factors promoting change

Patient's tearful episode during session 4 had been significant in revealing her avoidance of emotions and how it could affect therapeutic progress. The subsequent discussion about her stress towards coming to therapy had been fruitful for both of us to realize the importance of in-session sharing of feelings. It had effectively disconfirmed our doubt towards each other regarding the therapy. It illustrates the importance of mutual trust between patient and therapist.

5.3 Roadblocks to progress

Non-compliance to assignments was an issue in the therapy. More could be done to illustrate the value of the assignment and to motivate her to complete the assignment. Different modalities of assignments could have been added.

There were also difficulties in dealing with patient's emotional issue. Patient remained defensive at times and she had shown reluctance in leaving her comfort zone.

5.4 If I had my time again....

If I had my time again I would explore on assignment issue at an earlier stage of therapy. I would consider applying more behavioral components in the assignments. I would consider more in-vivo experiments during session. I would improve my skills on Socratic questioning and learn to be more sensitive in picking up cues during the session and give real-time responses if possible.

Appendix 2

Evaluation form for the psychotherapy case report for Hong Kong Psychiatric Training Scheme (February 2010)

Note: this form can be attached together with the ACE report form for trainees intending to apply CASC of MRCPsych examination. However the separate ACE report form has to be completed as well.

Name of trainee:

Name of psychotherapy supervisor (if applicable):

Name of psychotherapy trainer/trainer-in-charge:

Modality of psychotherapy delivered:

Duration of psychotherapy provided:

Diagnosis of the psychotherapy case:

The psychotherapy supervisor/ trainers' comments on the psychotherapy case report:

	Excellent	Good	Pass	Poor
Quality of the case formulation				
Definition of treatment goals and targets				
Appropriateness of the intervention strategies				
Competence in delivering intervention strategies				
Awareness of patient's and therapist's own reactions to therapy and therapeutic relationships				
Clarity of presentation				

Overall comments from the psychotherapy supervisor/ trainer:

Additional comments from the psychotherapy trainer-in-charge (if any):

Signature: _____ (Psychotherapy supervisor, if applicable)

_____ (Psychotherapy Trainer)

_____ (Psychotherapy trainer-in-charge, if any)

Date of completion of the evaluation form: _____