香港精神科醫學院

The Hong Kong College of Psychiatrists

Trainee Casebook

(2017 Edition)

Introduction

In 2008, the Hong Kong College of Psychiatrists commenced a continuous workplace-based assessment for doctors in psychiatric training in a “Trainee Casebook” format. The Trainee Casebook is a trainee-owned record of formal assessment of trainee competency in clinical assessment.

Apart from being a summative assessment, the Trainee Casebook also serves as a formative tool to facilitate feedback between the supervisor and the trainee. The Trainee Casebook helps to document areas of strengths and weaknesses in an individual trainee, and helps to focus on areas that require special attention.

To enhance clinical skills training, the Education Committee of the Hong Kong College of Psychiatrists has revised the requirements on the Trainee Casebook, with effect from January 2010.

Requirements

1. Applicability

The new requirements apply to:

a) Trainees who joined the training scheme in or after July 2009;

b) Trainees who joined the training scheme before July 2009 but have not yet passed the FHKCPsych Part I examination/MRCPsych Paper 1&2 examinations

(Trainees who joined the training scheme before July 2009 and have passed FHKCPsych Part I examination/MRCPsych Paper 1&2 examinations are exempted from the new requirements.)

2. Number of casebooks

a) Trainees are required to submit **seven** casebooks (four in General Adult Psychiatry, and three in other subspecialties) for completion of general professional training.

b) Two casebooks have to be completed within the first six months of training. Trainees are also required to complete one casebook during each subsequent 6-month rotation until they finish the above specified requirements.

c) Trainees who start their first rotation in Old Age Psychiatry will complete two casebooks in Old Age Psychiatry, followed by three casebooks in General Adult Psychiatry and two casebooks in other subspecialty rotations.

d) To be eligible to sit the FHKCPsych Part I examination (by the time of first application for examination), a trainee needs to have completed at least three casebooks satisfactorily.

e) To be eligible to sit the FHKCPsych Part II examination (by the time of first application for examination), a trainee needs to follow the schedule of submitting casebooks. For completion of general professional training, a trainee needs to fulfill the casebook requirements as specified above.

3. Schedule of submission of casebook

Please refer to the submission schedule as follows:

Rotation	No. of casebooks
General adult 1	2
General adult 2	1
General adult 3	1
Subspecialty 1	1
Subspecialty 2	1
Subspecialty 3	1

Rotation	No. of casebooks	To be submitted to EC by the end of
1st	2	1st year
2nd	1	1st year
3rd	1	2nd year
4th	1	2nd year
5th	1	3rd year
6th	1	3rd year

Each completed Casebook Assessment Form should be scanned into a PDF file, using the following naming format: “last name,first name,number.pdf”, e.g. “chan,john,1.pdf” for the first casebook and “chan,john,2.pdf” for the second and so forth. The PDF files of Casebook Assessment Form should then be submitted by email to hkcpsych@hkam.org.hk. Please enter “Casebook Submission” in the subject line of the email message. Do not submit by fax or by post. Trainees will be notified of receipt of their submission by email.

4. Variety of clinical cases

Trainees are encouraged to attempt a wide range of diagnoses in their casebooks. As a minimum, for the four casebooks completed in the rotations of General Adult Psychiatry, the primary and secondary diagnoses should fall into at least three of the following ICD-10 categories, of which one must be in Category iii and one in Category iv respectively.

i. F00+ (Organic)
ii. F10+ (Substance misuse)
iii. F20+ (Psychotic)

iv. F30+ (Affective)
v. F40+ (Neurotic)
vi. F50+ (Behavioural, adult onset)
vii. F60+ (Personality)
viii. F70+ (Mental retardation)

Trainees should discuss with their trainers about the competencies they need to attain, and the type and number of case assessments they should undertake to demonstrate attainment of these competencies.

Format

1. Case Selection

The process should be trainee-led. Therefore, the trainees should indicate to their trainers that they are ready for a formal assessment and arrangements should then be made.

The trainee selects a case of the appropriate level of complexity, preferably in consultation with their trainer. It should be agreed in advance that it will be a formal assessment.

New cases are preferred because they allow the trainees' skills in history-taking and examination to be assessed thoroughly.

2. Components

Completion of a clinical case involves two parts:

a) An interview with the trainer which includes a presentation of an individual patient assessment, an observed patient interview, and a discussion of diagnosis and aetiology.
b) A written case summary which includes the history, mental state examination, physical examination, final diagnosis (or diagnoses), aetiology, investigation, treatment, condition on discharge/current condition, and prognosis.

3. Setting

The simplest arrangement will be for the trainees to present and discuss the case for assessment during the weekly supervision session with their trainers. Other settings, such as outpatient clinic and accident-emergency department, are accepted as long as it is feasible. The trainers should be given enough notice to allot adequate time for the assessment.

4. Standard required and the use of assessment forms

The trainer should use the standardised assessment forms provided in the Trainee Casebook. For all cases, overall ratings of 4 or above are required in both parts, i.e. the interview and the case summary. Both the trainee and the trainer should be familiar with the assessment form, the areas of competency being assessed and the associated performance descriptors, as well as the standard required.

5. Domains of assessments

The first part of a case assessment, i.e. the interview which includes case presentation, observed patient interview and case discussion will consist of assessment on seven domains, each from a rating of 1 to 6. Rating should be made against the descriptors stated below.
(Adapted from those used in Assessment of Clinical Expertise (ACE) and assessment of case presentation by the Royal College of Psychiatrists.)

a. History taking: performance descriptors

i. Very poor, incomplete and inadequate history-taking
ii. Poor history taking which is badly structured and missing some important details
iii. Fails to reach the required standard; history-taking is probably structured and fairly methodical but might be incomplete although without major oversights
iv. Structured, methodical, sensitive; no important omissions
v. A good demonstration of structured, methodical and sensitive history-taking
vi. Excellent history-taking with some aspects demonstrated to a very high level of expertise and no flaws.

b. Mental state examination: performance descriptors

i. Fails to carry out more than the most rudimentary mental state examination through lack of skill, knowledge, etc.
ii. A poor and inadequate mental state examination, covering some of the basics but with significant inadequacies
iii. A reasonably satisfactory mental state examination but missing some relevant details
iv. A good mental examination covering all the essential aspects
v. A good, appropriately thorough and detailed mental state examination with no significant flaws or omissions
vi. A thorough, accurate and appropriate mental state examination, demonstrating excellent examination and communication skills

c. Communication skills with the patient: performance descriptors

i. Unacceptably poor communication skills
ii. Poor and inadequate communication skills; perhaps evidenced by poor listening skills, by body language or by inappropriately interrupting the patient

iii. Barely adequate communication skills, somewhat short of the required high standard, with perhaps one or more significant inadequacies
iv. A good standard of communication skills demonstrated throughout, with appropriate listening and facilitative skills and good body language; clearly reaches the high standard required
v. Exceeds the high standard required, with evidence from one or more aspects of excellent communication skills
vi. Excellent communication skills demonstrated throughout the encounter

d. Clinical judgment and interpretation of clinical evidence: performance descriptors

i. Fails to interpret clinical evidence correctly, gross omissions on differential diagnosis; practically no evidence of good clinical judgment.
ii. Fails to interpret clinical evidence correctly, many omissions and poor understanding of differential diagnosis; poor clinical judgment, clearly below the required standard
iii. May fail to interpret clinical findings correctly; some omissions and limited understanding of differential diagnosis; clinical judgment below the required standard but not dangerously so
iv. Good, logical clinical reasoning and judgment; could include a consideration of aetiology; an adequate differential diagnosis with no serious omissions
v. Insightful clinical judgment; an adequate differential diagnosis with good consideration of aetiology
vi. Excellent clinical judgment; comprehensive differential diagnosis considered with an excellent consideration of aetiology, including psychological aspects.

e. Case presentation: structure and content

i. Unsystematic; incomprehensible
ii. Unsystematic; inaccurate and/or incomplete
iii. Systematic but inaccurate and/or incomplete
iv. A systematic and logical presentation; the mental state examination and physical assessment should be accurate and appropriate demonstrating core (psycho)pathology; might have some omissions and/or inaccuracies but must be a systematic and logical presentation
v. Systematic, logical, accurate presentation; may have some minor omissions
vi. Systematic, comprehensive, logical and accurate presentation

f. Case presentation: command of language and presentation skills

i. Very poor command of language - inarticulate, very poor communication skills
ii. Poor command of language, inarticulate and easily misunderstood

iii. May have some difficulty in presenting information clearly
iv. Adequate communication but some problems, such as inappropriately slow delivery or signs of anxiety
v. Good communication skills, clear delivery of information
vi. Excellent communicator, clear and concise presentation of information

g. Overall rating of performance

i. Serious concern over the standard of clinical competency demonstrated
ii. Generally a poor standard of clinical competency, perhaps owing to one of more major shortcomings; there might be a few adequate aspects but nevertheless clearly sub-standard overall
iii. Clinical competency below the required standard but with no evidence of major inadequacy or oversight
iv. Clinical competency of the required standard, although possibly allowing a few minor shortcomings
v. A high standard of clinical care demonstrated but with no evidence of major inadequacy
vi. Evidence of excellent clinical competency in all aspects of the case- a role model

The second part of a case, i.e. the written case summary, will be given an overall rating from 1 to 6.

Overall rating of a case summary: performance descriptors

1. Very poor
2. Poor
3. Marginal
4. Pass
5. Good
6. Excellent

6. Feedback

Assessment of the interview should be followed by immediate feedback to the trainee. Feedback should always be clear and honest. There should be suggestions for development and agreed actions between the trainee and the trainer. The feedback should not just be a didactic process of the trainer informing the trainee of their strengths and weaknesses.

7. Failure and re-attempt

If the trainee fails part one of a case, he/she should choose another case to re-attempt. If the trainee fails part two of a case, he/she should amend the case summary according to the advice from the trainers until a satisfactory level is achieved.

Guidance notes for Part A of a case assessment (case presentation, observed patient interview and case discussion)

1. The interview with the assessor should occupy about 40 minutes. It should cover the following topics:

a) Assessment
b) Diagnosis and differential diagnosis
c) Aetiology

The assessor may raise general clinical or scientific questions stemming from consideration of the particular case. At the first year of training, trainees will not be expected to demonstrate detailed theoretical knowledge.

2. The trainee should be required to spend 15 to 20 minutes to interview his/her patient in the presence of the assessor, unless exceptional circumstances render this inappropriate.

PSYCHIATRIC HISTORY

1. A psychiatry history should include the following components:

a. Identifying information (age, gender, occupation, marital state, etc.)
b. Chief complaints
c. History of presenting illness
d. Past psychiatric history
e. Alcohol and substance misuse history
f. Past medical history
g. Family history
h. Personal history
i. Social circumstances
j. Any other relevant information pertaining to the individual patient

2. A good clinical history should demonstrate the following qualities:

a. Systematic: use of appropriate headings
b. Comprehensive: but not over-inclusive
c. Coherent and internally consistent

d. Has an appropriate sense of priorities and clinical relevance. Avoids unnecessary details
e. Multidimensional in approach: biological, psychological, social
f. Distinguishes appropriately between various categories of data: fact/opinion; description/explanation; direct/indirect
g. Accurate: good communication with patient
h. Due attention paid to the problem of reliability e.g. need for collateral data

MENTAL STATE

1. A mental state examination should have the following components:

a. Appearance and behaviour
b. Speech: amount and form
c. Thought content and form
d. Mood
e. Abnormal beliefs, delusions
f. Perceptual disturbances
g. Obsessional and compulsive phenomena
h. Cognitive function
i. Insight: attitudes to illness and its treatment

2. Trainees will be expected to be aware of definitions in descriptive psychopathology, at least at a basic level, and to show their knowledge of various manifestations of psychiatric symptoms.

In history taking and mental state examination, the trainee should demonstrate basic technique and qualities as a clinician.

PHYSICAL EXAMINATION

1. The extent of the physical examination has to be judged on a case by case basis, taking into account diagnostic possibilities.
2. However, it is most likely to focus on the examination of the central nervous system and the endocrine system. Physical examination should not, of course, be limited to these systems and all patients should have a full routine examination. Trainees will be expected to summarise important positive and negative findings.

Diagnosis

1. Trainees 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.
2. They should also be able to apply appropriate multidimensional approach and the concept of natural history of syndromes and disease.
3. They should list in order of probability diagnoses that should be considered and include any disorders which warrants investigation.
4. It is necessary to include any current physical illness that may account for some or all of the phenomena, and to give evidence for and against each diagnosis considered.
5. It is often necessary to consider supplementary diagnoses in addition to the primary diagnosis.

Aetiology

1. The trainee candidate should be able to discuss aetiological issues including social, psychological, or biological aspects.
2. The trainee should be able to address 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?*".
3. In many cases the trainee would need to describe the psychological factors involved.
4. For psychological factors, the trainee should be able to address the relative appropriateness of various frames of reference. Trainees are not expected to give a sophisticated psychological explanation.

Guidance note on Part B of a case assessment (the written case summary)

1. The trainee should prepare a written case summary which includes the psychiatric history, mental state examination, physical examination, final diagnosis/diagnoses, aetiology, investigation, treatment, condition on discharge/current condition, and prognosis.
2. This case summary should be completed upon the discharge of the patient or 4 weeks after the part one assessment of the case.
3. For the FHKCPsych Part I examination, the trainee should not be assessed for the management plan. Nonetheless, the trainers should give detailed advice to the trainee on investigation and treatment of the patient, so as to facilitate completion of the case summary.
4. For investigations, there should be an account of the investigations required to support the preferred diagnosis, to rule out alternatives and to improve understanding of the aetiology. The reasons for performing an investigation should be given, if they are not self-evident.
5. A thorough investigation of an illness requires effective enquiry into relevant domains of the biopsychosocial model; hence investigations should include psychological investigations as well as relevant social enquiries.
6. The biological, social and psychological aspects of treatment should be documented in details. It should include details of medications prescribed and the response, any significant side effects or rationale for changing medications. The importance of non-pharmacological treatment should be emphasised.
7. Description about the patient's condition on discharge should include medications, follow-up arrangement and other details of the care plan.
8. For prognosis, the trainee should make a predictive statement relating to symptoms and social adaptation, rather than using terms such as guarded, good or poor only.