Hong Kong Occupational Therapy Education and the emergence of the occupational therapy profession in Hong Kong

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Through occupational therapy can trace its beginnings in Hong Kong to the 1950's, the real development of the profession did not start until our first graduates from the occupational therapy education programme took up jobs in 1981, raising the work force numbers from around 25 to over 60 occupational therapists.

In 1977, a government white paper entitled *Integrating the disabled into the community: a comprehensive expanded social welfare services*, paved the way to creating the policy for a vast increase in rehabilitation facilities and services. New hospitals were on the construction charts. Outpatient polyclinics and other rehabilitation service facilities were being built. There were enormous requirements for medical and health services to grow extensively. Funding was being also advanced for improved social services.

This policy included the requirement for education of rehabilitation personnel, including occupational therapists. Negotiations for the situation of these new education programmes took place with the two universities, Hong Kong University and Chinese University of Hong Kong where there were already medical education programmes, as well as the HK Polytechnic. With these negotiations, considerations for teaching facilities and interdisciplinary developments were made. It was agreed by the Rehabilitation Advisory Committee to the government and the Medical and Health Bureau, that the Polytechnic was the most appropriate institution.

Setting up the programme

The Institute of Medical and Health Care was established at the Polytechnic
to cover six areas (occupational therapy, physiotherapy, radiography, medical laboratory science, nurse education and optometry). Speech therapy was considered to be better placed with languages rather than rehabilitation and was established to H K University. It was agreed initially that these courses would culminate in a Higher Diploma in the specific profession as was accepted at the time in Britain. Within two years the award had been upgraded to a Professional Diploma.

Two full time staff were hired. Angela Novak a Hong Kong resident from the UK and Philip Chan,

originally a psychiatric nurse who received a scholarship to attend the Cumberland College occupational therapy programme. I started in Nov 1978 as a part time staff but ended up working full time so took a full time contract in 1979.

A committee was set up including Penny Alexander Coombe from Cumberland College in Sydney was WHO consultant, Linda Wilson from New Zealand (QMH), Elsie White (medical superintendent), Dora Mowatt, the two full time staff, and myself. This group was formed to draw up the curriculum and specific syllabi for the occupational therapy programme. It relied heavily on the British and Australian OT education curriculum and took into account the need to meet WFOT Minimum Standards.

There was a need to start teaching almost immediately so the major subjects for year I were established first.

Teaching facilities

Occupational therapy was allocated one room to start our programme (L418) for 40 students. All practical sessions took place in this one room, requiring great innovation on the part of teachers and students. Lectures were provided in bigger lecture halls. Anatomy and psychology were offered as joint subjects with physiotherapy, though tutorials were separate. Practical classes like pottery and cooking were offered by other departments. In the third year of the programme, new premises were allocated to accommodate the expanding numbers of students.

Clinical education

My main job was to set up the clinical education aspect f the course. There were limited qualified OTs—about 25-- in the city, and few faculty teachers. I researched the format for clinical education, the assessment format, and ways to move forward. We decided the only way to offer quality tutorials and clinical experience was to split the class and sent half to clinical placement and provide practical sessions with the remaining half. This worked well but doubled the work-load for faculty.

As we took in a second cohort of students and in an attempt to cope with the increasing numbers needing placements and the workload of clinical staff, the programme took on the model used by Cumberland College of Clinical Education Units. This involved one senior staff being responsible for six students with a patient load allocated according to the requirements of the level of placement required. This system has continued and become more sophisticated over the years.

For the first cohort's final placement, six students were sent to Sydney for clinical education partly to relieve the pressure on local therapists who still had to carry their own workload. One student's comment on her return was, "Wow, they even do occupational therapy outdoors and they use 'play' with adults!" Learning about other cultures and approaches was part of the overseas experience.

As clinical coordinator, I visited all clinical setting to check on standards, support students and discuss feedback with students and clinical educators. This was possible partly because we have a small city area and because I had a car. Telephone discussion took place in-between visits. There were about 20 settings including hospitals, outpatients rehab, special schools and social service/work rehabilitation centres. The placements covered physical and psychiatric services, convalescent settings, and paediatrics. Clinical supervisor workshops and courses were run regularly to confirm standards, share experience, and ensure collaboration over student requirements.

New faculty

June Sparks was employed to teach anatomy. Then in 1980, Jennifer Creek was employed as Programme leader. Baboo Dasari was employed soon thereafter. The full time staff continued to expand. Part time staff were employed to provide specific course work over a number of years. The teaching staff from many diverse countries provided a variety of insights and experience which challenged students with a variety of different practice approaches and learning styles over the years to follow.

Occupational therapy association

In pursuit of international recognition for the programme, the Hong Kong Association of Occupational Therapists (HKAOT) was established in 1978 with Elsie White as first Chairman. It is interesting to note that, despite Hong Kong being a British Colony at the time, there was no connection between the HKAOT and the British Association of Occupational Therapists.

Regular meetings were held and committees established to address promotionof the profession especially in relation to other health care professions, education and continuing education, and other matters of concern at the time.

Applying for WFOT education approval and WFOT membership

The curriculum was sent to the WFOT Education Committee in 1980 and the course approval was backdated to 1978. Application was also made for acceptance of Hong Kong AOT as a member of WFOT. At the time of application, WFOT accepted only associations of sovereign nations. Hong Kong as a British Colony did not qualify. WFOT ratified a change to their constitution in order to accept Hong Kong as a full member.

In the 1980's in HK, a massive component of working with patients was related to post industrial accidents-particularly hand injuries caused by poor machine safety. The Splinting and hand therapy subject for the education programme was allocated over 30 hours of practical sessions. Now because the manufacturing industry has moved across the border, the heavy emphasis in Hong Kong on this kind o splinting has been reduced. It has been replaced by the treatment of clients with cumulative hand disorders and RSI --often for office workers. It is still hand therapy but with a different emphasis.

Another major area in the 80's was in burns therapy, using a new approach called pressure therapy

in combination with activities. At that time, many homes were still using Kerosene burners in the kitchen and cooking pots sat precariously on the burners. Children were admitted with burns down the front of their bodies from boiling water.

The incoming OT students had little experience of anything but being a student, so visits to factories were arranged and opportunities were set up to use wheelchairs on the busy Hong Kong streets. Assessing the new MTR for access and working with social service groups facilitated students to better understand the needs of Hong Kong people and consider community facilities and physical access in the housing estates where 70% of the population lived.

The first graduates had ready-made jobs in the Medical and Health Department with the new rank of Occupational Therapist II. As the course progressed and the new graduates expanded into new areas of practice every year, there was a need to develop job descriptions relevant to new fields of practice. Pilot projects were promulgated to establish new services in community and nursing homes. The HKAOT held mobile exhibitions and seminars for the public to promote awareness of occupational therapy in relation to specific health conditions. The Polytechnic offered open days and demonstrations to attract new admissions and convince parents that it was a job with good prospects.

The new graduates were at the forefront of the development of more localized occupational therapy assessments, some based on foreign evaluations and some based in the cultural perspectives of the Hong Kong Chinese. An example of this being the developmental scale of children in Hong Kong as Hong Kong children tended to demonstrate more advanced hand development and slower gross motor development than foreign assessments might indicate. Specific local ADL assessments focused on eating with raised bowl and chopsticks, on accommodating for a squat toilet, and for bathing with a bucket rather than a bathtub using a towel which needed to be rung out in the Asian style.

Discussion about registration of occupational therapists began under the then Council of Professions Supplementary to Medicine. Should Hong Kong follow the British system of Part 1 and Part 2 which required one year of supervised practice? The negotiations went on for about ten years. One rationale for occupational therapists going ahead with this designation was that registration meant that doctors could not hire nurses to do the job of the OT. In 1991, the Ordinance (SMPC Cap 359) was enacted for occupational therapists. This ordinance also covered medical laboratory technician. These two health care professions were the first to gain practice registration in Hong Kong which limits the practice of their professions to those who hold appropriate qualifications. The Physiotherapy Association held out for a law which would allow them to go into private practice directly upon graduation. In 1997, their ordinance was passed stipulating a part 1a and 1b which is similar to the OT's part 1 and 2.

The Polytechnic became a university in 1991 changing the course of education development. The Department of Rehabilitation Sciences was formed. Some of the first graduate became lecturers,

having gone overseas to study. The demand for post graduate course increased. Eventually Masters and PhDs were offered by the Department. Local lecturers replaced overseas teachers to make up a majority of the faculty. The occupational therapy education progamme at the Polytechnic University has gone from strength to strength and the demand for occupational therapists in the medical and social sectors has increased. Along with the change in demographics, e.g. aging population, and emphasis on community oriented care, a second occupational therapy Bachelor programme has been started.

There are now more than 1670 registered occupational therapists in Hong Kong, many of them with Masters degrees and PhD's who are serving the health care needs of the Hong Kong population.

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香港职业治疗教育与职业治疗专业的出现（中文摘要）

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虽然香港职业治疗的历史可追塑至 1950 年代，但这专业真正的发展要算到 1981 年第一批本地培训的毕业生，把当时的职业治疗师目从 25 增加至 60 人。1977 年《群策群力--协助弱能人士更生》白皮书制订了大量增加康复设施和服务的政策。政府计划兴建新的医院、日间综合诊所及其它康复服务设施。这政策亦涉及康复人员的教育，包括职业治疗师。在香港大学、香港中文大学和香港理工学院三间院校中，政府选择了后者作为培训院校。

课程的建立

开始招生时职业治疗是一「高级文凭」课程，两年后提升为「专业文凭」。早期只有两位全职教师：Angela Novak 和 Philip Chan。我在 1978 年加入成为兼职老师，到 1979 年才转为全职。我加入了由多位本地及海外治疗师组成的委员会，制定课程大纲。课程内容主要参考英国和澳洲的课程及世界职业治疗师联盟职业治疗师教育最低标准。

教学设施

我们最初时只有一间房间开展 40 位学生的讲课和实习。解剖学和心理学是与物理治疗学生一起上课，所以可以在较大的演讲室上课，辅导课则分开。需要操作的课程，如陶艺、煮食等则由其它部门提供。由于学生的数目增加，1981 年终有新的较大的教学场所分配给职业治疗。

临床教育

我当时的工作还有为课程建立临床教育的部份。当时香港的职业治疗师只有 25 人，经过参考其他临床教育模式，我决定授取分批到医疗机构医床实习，留在校内的学生则提供技术的训练。这模式可行但增加了教师的工作量。由于学生数目增加，课程采纳了澳洲 Cumberland College 临床教学组的模式，由一位高级职业治疗师临床同时指导六位学生。这模式一直沿用至今。有六位第一届学生在最后一次临床实习，被送到澳洲悉尼，吸取外国不同文化的治疗文法。

作为临床实习的联络人，我需要到不同机构与临床带教老师讨论学生的表现和水平，并要给予学生支持和反馈。当时提供临床实习的机构包括医院、门诊复康中心、特殊学校、社会服务/职业康复中心等。服务范围包括普通科、精神科服务、疗养院舍及儿科等。我们还组织课程和工作坊给临床带教老师，目的包括统一标准、分享经验，以配合学生的需要。

教职员

初时教解剖学的是 June Sparks. 1980 年 Jenifer Creek 是课程主任，Baboo Dasari 也很快加入教职员行列。全职教师的数目续惭增加，兼职教师教授特别科目也维持了好几年。教师来自不同国家，这给学生带来更广阔的视野和学习模式。

职业治疗学会

为了争取国际认可，香港职业治疗师协会在 1978 年成立，而第一任会长是 Elsie White。当时协会的工作包括向其它医疗行业介绍我们的专业，推行教育及持续教育等事项。

申请世界职业治疗师联盟的课程认可及会籍

课程在 1980 年向世界职业治疗师联盟教育委员会申请认可资格，并获得批准及追溯到 1978 年。香港职业治疗师协会也正式成为世界职业治疗师联盟的会员。在当时，因为香港不是一个主权国家，世界职业治疗师联盟修改了宪章使香港成为基本会员。

在八十年代的香港，因工业意外引至不少手创伤的病人，所以课程设计在手康复及复康支具制作超过 30 学时。由于制造工业的北移，课程对复康支具已没有那么重视，并以累积性劳损的治疗替代，尤其是对办公室工作者。这时期的另一个发展领域是利用压力衣与治疗性活动治疗烧伤病人，因当时不少使用火水炉引起火警及小孩给滚水烫伤的案例。

为了增加当时学生的生活经验，课程安排他们参观工厂及在繁忙街道使用轮椅。亦让他们评估地铁及各屋邨设施是否适合有残疾的人士使用。

第一届毕业生大多在当时的医务卫生署工作，职位是二级职业治疗师。以后的毕业生更在

不同性质的机构工作，扩大了职业治疗的服务范围。其它的发展还有在小区及老人院开展新服务。当时的 “香港职业治疗师协会”也通过展览和会议向大众推广职业治疗与健康的关系。理工学院亦透过开放日吸引新生入学。

新毕业生由于工作的须要，发展了不少本地化的评估，例如香港儿童发展评估表，因为香港儿童的手部发展较早，但粗大动作则较慢。亚洲人在日常生活上与西方也有分别，例如使用碗筷进食，使用蹲厕和水桶洗澡等。

在专业注册事宜上，有关是否采用英国系统的第一及第二部分注册模式的讨论约十年之久，论点在第二部分注册的治疗师是否须要在第一部分注册的治疗师一年的督导下工作才能独立执业？专业注册的概念是保证专业水平及市民的福祉。《辅助医疗条例．359 章》终于在 1991 年适用于职业治疗师，同期执行的还有医务化验师。物理治疗师的注册在 1997 年开始执行，法例要求未有一年「认可经验」的治疗师先在 1b 部分注册，这与职业治疗师的第一及第二部分注册模式相似。

1991 年理工学院升格为大学，这推动了课程的转变。康复科学学系亦正式成立，有些第一届的毕业生去外国学习后也成为讲师。市场对更高学历的需求不断增加，结果理工大学亦增加了硕士与博士的培训，本地训练的讲师亦陆续替代外国讲师。由于医疗与社会机构对职业治疗师的需求日惭增加。随着人口结构的变化，例如人口老龄化，发展重点将如强小区的服务，现时已有第二所职业治疗本科课程培训学生。现时香港注册的职业治疗师超过 1670 人，其中不少拥有硕士或博士学位。

职业治疗临床学习与培训

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引言

职业治疗是一门将科学应用在临床治疗的辅助医疗专业，目的是协助有不同病患的人士恢复功能，再融合于生活的不同岗位和角色，重建有意义的生活。因此之故，在职业治疗的课程中，临床学习与实践是每位学员必经的基础训练，也是这课程中不可或缺的一环，以培育学员建立高水平的专业服务能力。事实上，国际专业认可的职业治疗基础课程，内容必须包括最少一千小时的临床学习和实践，并且在不同领域，如身体残障和精神病患的康复治疗中取得临床经验，才能获得职业治疗的专业资格。我有幸在过去二十年有份参与临床教学的工作，见证了一代接一代职业治疗精英的出现，他们现今都能在不同岗位领域上领导发展，更且青出于蓝。而当同侪有机会聚首交流时，除了分享大计及发展外，也会回味昔日学习和受训时的经历。可