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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香港職業治療教育與職業治療專業的出現（中文摘要）

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雖然香港職業治療的歷史可追塑至 1950 年代，但這專業真正的發展要算到 1981 年第一批本地培訓的畢業生，把當時的職業治療師目從 25 增加至 60 人。1977 年《群策群力--協助弱能人士更生》白皮書制訂了大量增加康復設施和服務的政策。政府計畫興建新的醫院、日間綜合診所及其它康復服務設施。這政策亦涉及康復人員的教育，包括職業治療師。在香港大學、香港中文大學和香港理工學院三間院校中，政府選擇了後者作為培訓院校。

課程的建立

開始招生時職業治療是一「高級文憑」課程，兩年後提升為「專業文憑」。早期只有兩位全職教師：Angela Novak 和 Philip Chan。我在 1978 年加入成為兼職老師，到 1979 年才轉為全職。我加入了由多位本地及海外治療師組成的委員會，制定課程大綱。課程內容主要參考英國和澳洲的課程及世界職業治療師聯盟職業治療師教育最低標準。

教學設施

我們最初時只有一間房間開展 40 位學生的講課和實習。解剖學和心理學是與物理治療學生一起上課，所以可以在較大的演講室上課，輔導課則分開。需要操作的課程，如陶藝、煮食等則由其它部門提供。由於學生的數目增加，1981 年終有新的較大的教學場所分配給職業治療。

臨床教育

我當時的工作還有為課程建立臨床教育的部份。當時香港的職業治療師只有 25 人，經過參考其他臨床教育模式，我決定授取分批到醫療機構醫床實習，留在校內的學生則提供技術的訓練。這模式可行但增加了教師的工作量。由於學生數目增加，課程採納了澳洲 Cumberland College 臨床教學組的模式，由一位元高級職業治療師臨床同時指導六位學生。這模式一直沿用至今。有六位第一屆學生在最後一次臨床實習，被送到澳洲悉尼，吸取外國不同文化的治療文法。

作為臨床實習的聯絡人，我需要到不同機構與臨床帶教老師討論學生的表現和水準，並要給予學生支持和回饋。當時提供臨床實習的機構包括醫院、門診複康中心、特殊學校、社會服務/職業康復中心等。服務範圍包括普通科、精神科服務、療養院舍及兒科等。我們還組織課程和工作坊給臨床帶教老師，目的包括統一標準、分享經驗，以配合學生的需要。

教職員

初時教解剖學的是 June Sparks. 1980 年 Jenifer Creek 是課程主任，Baboo Dasari 也很快加入教職員行列。全職教師的數目續慚增加，兼職教師教授特別科目也維持了好幾年。教師來自不同國家，這給學生帶來更廣闊的視野和學習模式。

職業治療學會

為了爭取國際認可，香港職業治療師協會在 1978 年成立，而第一任會長是 Elsie White。當時協會的工作包括向其它醫療行業介紹我們的專業，推行教育及持續教育等事項。

申請世界職業治療師聯盟的課程認可及會籍

課程在 1980 年向世界職業治療師聯盟教育委員會申請認可資格，並獲得批准及追溯到 1978 年。香港職業治療師協會也正式成為世界職業治療師聯盟的會員。在當時，因為香港不是一個主權國家，世界職業治療師聯盟修改了憲章使香港成為基本會員。

在八十年代的香港，因工業意外引至不少手創傷的病人，所以課程設計在手康復及複康支具製作超過 30 學時。由於製造工業的北移，課程對複康支具已沒有那麼重視，並以累積性勞損的治療替代，尤其是對辦公室工作者。這時期的另一個發展領域是利用壓力衣與治療性活動治療燒傷病人，因當時不少使用火水爐引起火警及小孩給滾水燙傷的案例。

為了增加當時學生的生活經驗，課程安排他們參觀工廠及在繁忙街道使用輪椅。亦讓他們評估地鐵及各屋邨設施是否適合有殘疾的人士使用。

第一屆畢業生大多在當時的醫務衛生署工作，職位是二級職業治療師。以後的畢業生更在

不同性質的機構工作，擴大了職業治療的服務範圍。其它的發展還有在社區及老人院開展新服務。當時的“香港職業治療師協會”也通過展覽和會議向大眾推廣職業治療與健康的關係。理工學院亦透過開放日吸引新生入學。

新畢業生由於工作的須要，發展了不少當地語系化的評估，例如香港兒童發展評估表，因為香港兒童的手部發展較早，但粗大動作則較慢。亞洲人在日常生活上與西方也有分別，例如使用碗筷進食，使用蹲廁和水桶洗澡等。

在專業註冊事宜上，有關是否採用英國系統的第一及第二部分註冊模式的討論約十年之久，論點在第二部分註冊的治療師是否須要在第一部分註冊的治療師一年的督導下工作才能獨立執業？專業註冊的概念是保證專業水準及市民的福祉。《輔助醫療條例．359 章》終於在 1991 年適用于職業治療師，同期執行的還有醫務化驗師。物理治療師的註冊在 1997 年開始執行，法例要求未有一年「認可經驗」的治療師先在 1b 部分註冊，這與職業治療師的第一及第二部分註冊模式相似。

1991 年理工學院升格為大學，這推動了課程的轉變。康復科學學系亦正式成立，有些第一屆的畢業生去外國學習後也成為講師。市場對更高學歷的需求不斷增加，結果理工大學亦增加了碩士與博士的培訓，本地訓練的講師亦陸續替代外國講師。由於醫療與社會機構對職業治療師的需求日慚增加。隨著人口結構的變化，例如人口老齡化，發展重點將如強社區的服務，現時已有第二所職業治療本科課程培訓學生。現時香港註冊的職業治療師超過 1670 人，其中不少擁有碩士或博士學位。

职业治疗临床学习与培训

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引言

職業治療是一門將科學應用在臨床治療的輔助醫療專業，目的是協助有不同病患的人士恢復功能，再融合於生活的不同崗位和角色，重建有意義的生活。因此之故，在職業治療的課程中，臨床學習與實踐是每位學員必經的基礎訓練，也是這課程中不可或缺的一環，以培育學員建立高水準的專業服務能力。事實上，國際專業認可的職業治療基礎課程，內容必須包括最少一千小時的臨床學習和實踐，並且在不同領域，如身體殘障和精神病患的康復治療中取得臨床經驗，才能獲得職業治療的專業資格。我有幸在過去二十年有份參與臨床教學的工作，見證了一代接一代職業治療精英的出現，他們現今都能在不同崗位領域上領導發展，更且青出於藍。而當同儕有機會聚首交流時，除了分享大計及發展外，也會回味昔日學習和受訓時的經歷。可