Sandra Schiller

· Physiotherapie
· Ergotherapie
· Logopädie

Fachenglisch für Gesundheits-berufe

2. Auflage

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Physiotherapie, Ergotherapie, Logopädie

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- Ergotherapie
- Logopädie

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Christina Kritter, Judith Holzknecht und
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Vorwort zur 2. Auflage

Schon vor Erscheinen der ersten Auflage von „Fachenglisch für Gesundheitsberufe“ zeichnete sich der Bedarf an einem solchen Sprachlehrbuch ab. Die Tatsache, dass schon nach kurzer Zeit eine zweite Auflage erforderlich wurde, bestätigt diesen Eindruck.

Seit Erscheinen des Buches freue ich mich über das positive Feedback von Kolleginnen und Kollegen der Physiotherapie, Ergotherapie und Logopädie im In- und Ausland, von Dozentinnen und Dozenten für Fachenglischkurse an Berufsfachschulen und Fachhochschulen sowie nicht zuletzt von Schülerinnen und Schülern bzw. Studierenden.

Besonders erfreulich ist dabei, dass der interdisziplinäre Ansatz und der Fokus des Buches auf den Gemeinsamkeiten der drei Berufsgruppen vielfach als bereichernd empfunden wird, auch wenn somit bei einem Buch diesen Umfangs die einzelnen Berufsgruppen nicht in aller thematischen Breite vorgestellt werden können.

Die zweite Auflage präsentiert die Texte und Übungen noch übersichtlicher und macht sie damit leichter zugänglich. Zusätzlich bietet die zum Buch gehörige Homepage des Springer-Verlags ein zusätzliches Angebot, das die Möglichkeiten zum selbstständigen Lernen und Vertiefen erweitert und v. a. Lernenden mit geringeren Englischkenntnissen hilft, sich die Inhalte des Buches besser zu erschließen.

Im Internet finden Sie:

- alle Fragen und Übungen sowie alle Beachte-Hinweise (Notes) in deutscher Übersetzung
- eine umfangreiche englisch-deutsche Vokabelliste als Nachschlagewerk
- thematische englisch-deutsche/deutsch-englische Vokabellisten zu den einzelnen Kapiteln bzw. Themen der Units zum aktiven Vokabellernen und zum Überprüfen der „Active-Vocabulary-Übungen“
- eine Übersicht zu Unterschieden in der britischen, amerikanischen und kanadischen Schreibweise.

Ich wünsche auch der zweiten Auflage eine gute Aufnahme beim interessierten Fachpublikum und freue mich über Ihre Anmerkungen und Anregungen.

Sandra Schiller
Hildesheim im Februar 2009

Vorwort zur 1. Auflage

Berufsangehörigen, SchülerInnen und Studierenden in den deutschsprachigen Ländern einen umfassenden Einstieg in das Fachenglisch für die Gesundheitsberufe Physiotherapie, Ergotherapie und Logopädie zu bieten, ist das Ziel dieses Buchs. Die Tatsache, dass es sich gleichermaßen an alle drei Berufsgruppen wendet, reflektiert die für den angelsächsischen Bereich charakteristische **interdisziplinäre Ausrichtung** der drei Berufe und verdeutlicht ihre gemeinsamen Interessen und Perspektiven.

TherapeutInnen, die sich für eine Auslandstätigkeit entscheiden, interessieren sich erfahrungsgemäß für viele verschiedene englischsprachige Länder, von Kanada bis Neuseeland. Es ist eine Besonderheit von „Fachenglisch für Gesundheitsberufe", diese **Pluralität der sprachlichen und kulturellen Erfahrung** zu berücksichtigen: Die physiotherapeutischen Beispiele stammen schwerpunktmäßig aus Großbritannien/Irland, die ergotherapeutischen schwerpunktmäßig aus den USA und die logopädischen schwerpunktmäßig aus Kanada. Um dabei keine unnötige Verwirrung hinsichtlich unterschiedlicher Schreibweisen usw. zu verursachen, wird durchgängig die Orthographie des britischen Englisch verwendet.

Der inhaltliche Schwerpunkt des Buches liegt auf dem Bereich des **beruflichen Handelns und der Kommunikation zwischen TherapeutInnen und KlientInnen** (▶ Units 3–5). Zur Vorbereitung auf eine Auslandstätigkeit werden nicht nur typische Redewendungen für die therapeutische **Gesprächssituation** behandelt, sondern auch die verschiedenen Arten von **beruflicher Dokumentation** (von Fallaufzeichnungen bis Arztbericht) mit Beispielen vorgestellt. Darüber hinaus bietet das Buch einen Einblick in weitere relevante Themen wie etwa **Gesundheitswesen, Hochschulbereich und Auslandsbewerbung**. Obwohl der Aufbau einer logischen Struktur folgt, können die einzelnen Units auch in beliebiger Reihenfolge gelesen oder erarbeitet werden.

Mit einer Mischung aus Informationstexten, praktischen Beispielen, Wortschatzübungen, Rechercheaufgaben sowie Reflexions- und Diskussionsfragen eignet das Buch sich nicht nur für die Verwendung in einem **Sprachkurs**, sondern auch für das **Selbststudium**. Um zu einem erschwinglichen Preis einen möglichst breiten Überblick bieten zu können, sind die zum Buch gehörige umfangreiche deutsch-englische/englisch-deutsche **Vokabelliste** und weitere aktuelle Informationen über die Webseite des Springer-Verlags zugänglich. Im Buch selbst bietet der **Appendix** einen schnellen Zugriff auf häufig benötigte Informationen wie z.B. im Gesundheitsbereich gebräuchliche Abkürzungen, Therapiematerialen und -geräte, Körperebenen und Richtungsangaben sowie nützliche Redewendungen für das Therapiegespräch und für Vorträge bzw. Referate.

Ich wünsche Ihnen viel Freude an der Arbeit mit diesem Buch und viel Erfolg in Ihrer beruflichen Kommunikation in englischer Sprache!

Über Ihre Rückmeldungen und Anregungen würde ich mich freuen.

Sandra Schiller
Hildesheim im August 2007

Acknowledgements

First of all I owe a very big thank you indeed to my three wonderful collaborators, Christina Kritter (MSc SLT), Judith Holzknecht (BSc PT) and Barbara Mohr-Modes (MSOT) for all their great ideas and contributions to their respective subject areas. It was a real pleasure working with them!

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Last but not least, I am gratefully amazed that Dr Christiane Schlaps has managed to keep up an interest in this topic even though it could not be further from her own professional pursuits.

Weitere Beiträge

Ines Klämbt und Sandra Schoeren. The Physiology of Voice (▶ Unit 2.7).
Kirstin Lambrecht. Doing Further Training: The PNF Course in Vallejo, California (▶ Unit 7.1).
Katharina Matzel. Stuttering Treatment Programme of the American Institute for Stuttering (AIS) (▶ Unit 6.4).
Britta Neumann. The Therapeutic Relationship and the Intervention Process (▶ Unit 4.1), OT Exercise in ▶ Unit 4.5 und Liste "Materials and Tools Often Used in Paediatric Occupational Therapy" (Appendix).
Ute Rüdiger. Charity Work: A Physiotherapist in East Africa (▶ Unit 7.1).
Hanna Runge. Working for a School Board in the USA (▶ Unit 3.8).
Sonia Wilson. Doing a Bachelor's Degree – An Occupational Therapy Student's Perspective (▶ Unit 6.6).
Daniela Wolter. Practical Experience as an Occupational Therapist in the Southwest of Africa (▶ Unit 7.1).

Margit Franke (SLT), Britta Neumann (OT) und Katrin Hilpert (PT) erarbeiteten die Übersetzung von fachspezifischem Vokabular.
Dr. Bryan Ruppert (Seattle University) beriet bei der Unterscheidung zwischen amerikanischem und britischem Sprachgebrauch hinsichtlich Vokabular und Orthographie.

Contents

Unit 1: Health and Health Care

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1.1 Not Feeling Well

Jenny is an RGN and works in an acute hospital in Dublin. Today she is out to meet her best friends, Judy and Daniel, for lunch. Judy works in the private sector as a health care assistant and Daniel is a physiotherapist.

Jenny: Hi folks, how is it going?

Judy: Oh, as usual very busy. How are you? I haven't seen you around much!

Daniel: That's right, it feels like we haven't seen you for ages!

Jenny: Ah well, I'm fine. You know what it's like…

Daniel: Oh well, indeed. So what will we have for lunch then?

Judy: I don't know… What about something light, perhaps a salad?

Jenny: Sounds great, salad it is then.

Judy: Yeah, really, I'm not in good form today. I'm feeling a bit light-headed and nauseous. I think we might have another one of these bugs going around – another winter vomiting bug, you know. So I just feel a little weak.

Daniel: Isn't it strange the way you can never really get rid of these bugs? They just seem to spread around on a regular basis. And we have such strict hygiene rules in our hospitals, if you think of it. It's appalling!

Jenny: Well, the general public has quite a lot to do with it as well, you know. People simply don't understand the nature of the problem and that they are a primary source of spreading infection in the hospital if they don't decontaminate their hands and wear aprons.

Judy: That reminds me of one of my elderly ladies who I used to look after. She caught the bug last year and RIP'd shortly after. Really sad story. She was such a fighter and… there you go! And if I think of her son – always on sick leave! For benefits, you know. He never admitted it, but it was so obvious! He was in a car crash five years ago and suffered from bad whiplash afterwards. I believe he was really bad immediately after that, but come on, five years later?! I don't know…

Daniel: It is quite a bad condition, whiplash, you know… you can't just get rid of it very easily. It often takes a long time and a lot of physio to sort you out again.

Judy: I know, but he is a real hypocrite. On benefits and ongoing sick leave ever since it happened, but a lot of cash-in-hand jobs, if you know what I mean. Really awful! Well, I suppose you always get those, don't you?

Jenny: But you also get a lot of decent people, you know that. We had a gentleman in the other day and he suffered from a really bad flu. Also he had a nasty injury to his right shoulder. He had fallen off some scaffolding, he's a builder, you know. Mr Simmons said he was going to sign him off for a week, but he refused. Well, initially he did, but agreed to it in the end. He simply could not have gone back to work straight away. See, you do get all sorts in our jobs.

Judy: Well, I suppose you are right, but let's not spend our time talking about being ill all the time.

Daniel: We're off for the moment, so let's talk about nicer things than that, okay? Look, our lunch! Have a nice meal!

Note

While surgeons carry the appellation "Dr" in North America, fellows of the Royal College of Surgeons in the UK are referred to as "Mr" or "Ms". This peculiar habit is a reference to the historical origin of surgeons who did not attend medical school but were simply skilled tradesmen.

Exercise

Make a list of all the words related to states of health that you can find in the dialogue. What do they mean in German?

Find a conversation partner to talk about the state of your own (or other people's) health and fitness and see how many words from the text or from the list below you can use. Feel free to make something up altogether.

Active Vocabulary: Not Feeling Well

in good health	in good shape	to be taken ill	to fall ill
unwell	miserable	exhausted	weakened
infirm	feeble	bedridden	to be off colour
to feel kinda funny	to feel run down	to be/feel under the weather	to be/feel out of sorts

Note

In American English "being sick" or "feeling sick" means "krank sein" or "sich krank fühlen". In British English the expression "being ill" or "feeling ill" is more common. In British English, "feeling sick" or "being sick" may be used synonymously with "feeling ill" or "being ill" but it can also mean "feeling nausea" and "vomiting".

Additional info online

Note

The vocabulary from this chapter may also be useful for some of the exercises in
► Unit 4.

1

1.2 Introduction to Health and Ill Health

Health

In its most basic form the word "health" refers to the **absence of disease**. The most commonly accepted definition of health is that of the World Health Organization (WHO), which states that "health is a **state of complete physical**, **mental and social well-being** and not merely the absence of disease or infirmity"[1]. By extending the meaning of health to encompass the psychological and the social dimension, this by now classical definition stated that disease and infirmity cannot qualify health if regarded in isolation from **subjective experience**. In the 1970s and 1980s, the WHO's holistic view of health was further widened to include the components of intellectual, environmental and spiritual health. This broad understanding of **health as "well-being"** has ultimately also contributed to the current popularity of the concept of "wellness" in industrialized countries.

However, the WHO definition has also met with some antagonism: some critics argue that such a comprehensive notion of health makes it difficult to distinguish "health" from "happiness", while others maintain that health cannot be defined **as a state** at all, but must be seen **as a process** influenced by the shifting demands of daily living and the fluctuating meanings people attribute to their lives. They therefore consider the WHO definition to be more idealistic than realistic.

Health promotion

According to the WHO definition originally presented at the **Ottawa Conference**, the first international conference on health promotion, in 1986: "Health promotion is the process of enabling people to increase control over, and to improve, their health." The following **five categories** were considered essential for the goals of health promotion: building healthy public policy, creating supportive environments for health, strengthening community action, developing personal skills, and reorienting health services. In recent years, the concept of individual responsibility and the adoption of healthy lifestyles have additionally become a focus of attention.

Health promotion incorporates the areas of disease prevention, health protection and health education. The aim of **disease prevention** is to protect as many people as possible from the harmful consequences of threats to their health, e.g. through immunization campaigns. **Health protection** deals with regulations and policies such as the implementation of a no-smoking policy at the workplace or the commitment of public funds

1 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 states (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

to the provision of accessible leisure facilities in order to promote fitness and well-being. The aim of **health education** in schools or primary health care settings is to influence behaviour and to help individuals, groups, or whole communities to develop positive health attributes through the promotion of issues such as physical fitness, weight loss, healthy nutrition, stress management, etc.

Active Vocabulary: Odd One Out

Decide which of the words listed below is *not* a synonym for the word used in the text. Please look up unfamiliar words in a general dictionary. One example has already been done for you.

commonly (line 1.2)	widely – publicly – usually
merely (line 1.4)	~~gradually~~ – only – simply
to encompass (line 1.5)	enclose – inhabit – include
current (line 1.11)	topical – present – remote
comprehensive (line 1.14)	concise – elaborate – extensive
notion (line 1.14)	idea – understanding – theory
to distinguish (line 1.15)	differentiate – vary – discriminate
to maintain (line 1.15)	claim – argue – keep
implementation (line 2.14)	installation – publication – execution
accessible (line 2.16)	open – restrained – available

Active Vocabulary: Health and Health Promotion

Additional info online

The English equivalents to these German words are used in the text. What are they?

- gesund = _____
- Gesundheitsförderung = _____
- gute körperliche Verfassung = _____
- Krankheitsprävention = _____
- Schwäche, Gebrechlichkeit = _____
- Wohlbefinden, Gesundheit = _____

Discussion

1. **Do you consider the WHO definition of health to be realistic or idealistic? Give reasons in support of your answer.**
2. **Are there any other widely recognized definitions of health?**
3. **Can health be defined as a state? Give reasons in support of your answer.**
4. **Have a look at the following statement taken from the Recommendations of the 2nd International Conference on Health Promotion (Adelaide, Australia, April 1988):**

"Prerequisites for health and social development are peace and social justice; nutritious food and clean water; education and decent housing;

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a useful role in society and an adequate income; conservation of resources and the protection of the ecosystem. The vision of healthy public policy is the achievement of these fundamental conditions for healthy living." (Source: WHO. Global Conferences on Health Promotion. http://www.who.int/healthpromotion/conferences/previous/adelaide/en/index5.html)

5. **Do you think that health exists in our society? What are the implications for global public health?**

Group Activity

Imagine you were to support a health promotion campaign. Get together with some fellow students in a small team and think of a specific event. What would be your target group(s)? Which types of activities would you organize? How would you go about it?

Disease and Illness

Physicians typically make a distinction between disease and illness. In their understanding, the term **disease** usually refers to a structural problem in the body that can be measured, studied under a microscope or diagnosed by a test. A disease is an abnormal condition of the body or mind that causes discomfort, dysfunction or distress to the person suffering from it. "Disease" is sometimes used as an umbrella term that includes syndromes, symptoms, injuries, disabilities, deviant behaviours, etc. In contrast, a person's subjective perception of having poor health is generally called **illness** or **sickness**. This crucial distinction between the two terms means that one person can have a disease and still feel healthy and fit, while another one feels ill and is convinced he or she is suffering from an illness, even though no disease can be detected.

Diseases can be serious, like ALS, or trivial, like the common cold. Some diseases are silent, like diabetes or high blood pressure, and only discovered by running a test. Hereditary diseases, like haemophilia, are genetically passed from parents to children. Most congenital diseases are hereditary. While some diseases, such as AIDS, are contagious or infectious, others cannot be spread from person to person. Industrial diseases like pneumoconiosis are caused by hazardous or polluted work environments.

The recognition of a specific medical condition as a disease can have significant positive or negative social or economic implications for the individual as well as for public or private health care providers. Whether a condition is considered a disease may vary from culture to culture or over the course of time. Post-traumatic stress disorder, whiplash injury, attention deficit hyperactivity disorder or even obesity are just some examples of conditions that were not considered diseases some decades ago or are not recognized as such in all countries.

Symptom and Sign

The classification of a particular feature in health care as a sign or a symptom strictly depends on who observes it. Any sensation or change in health function experienced by the patient is considered a **symptom**, which may be characterized as weak, mild or strong. Thus, symptoms refer to a patient's subjective report of the state he or she is in. Pain, nausea, fatigue, etc. are symptoms as they can only be perceived and related by the patient. The cause of concern which makes a patient seek medical advice is called a "presenting symptom" or "presenting complaint", whereas the symptom leading to a diagnosis is known as the "cardinal symptom".

In contrast, a **sign** is regarded as "objective" evidence of the presence of a disease or disorder as detected by a physician or a therapist during the physical examination of a patient. The expression "clinical sign" is also common – it emphasizes that the observation takes place in a clinical context. Nystagmus, ataxia, joint inflammation, muscle spasm, etc. are by necessity signs, as they can only be identified by physicians or other health professionals. They can give the doctor or therapist important clues about which disease may lie behind the patient's symptoms.

A collection of signs or symptoms that occur together is commonly called a **syndrome**.

Active Vocabulary: Disease and Illness I

Additional info online

What are the English equivalents of the words listed below? They are all used in the above text.

- abweichendes Verhalten = _____
- Adipositas = _____
- Behinderung = _____
- Fehl-, Dysfunktion =_____
- Krankheit = _____
- Krankheit (spezif.) = _____
- Kummer, Verzweiflung, Not, Leiden = _____
- posttraumatisches Belastungssyndrom = _____
- schlechter Gesundheitszustand = _____
- Schleudertrauma = _____
- Unbehagen, Unwohlsein = _____
- Verletzung = _____

Questions

1. **What are the various possible causes of disease?**
2. **Why is it relevant that a condition is recognized as a "disease"? Some reasons are mentioned in the text but you can probably think of some more.**
3. **Can you give any examples of cultural or historical differences in illness perception or the recognition of diseases?**
4. **What is the difference between a symptom and a sign?**

1

Discussion

"Individuals from different cultures perceive and experience illness within the context of their cultural backgrounds. These experiences are not uniform, and attempts to discount them will lead to significant dilemmas in their treatment" (Bonder, Martin & Miracle, 2002, p. 68).

What do you think of this statement? Can you give any examples from your own professional experience that support or refute it? Please discuss.

Exercise: Opposites

These adjectives are all used to talk about diseases, their symptoms and effects. Match the words in italics with their opposites in the table. The first One has already been done for you as an example.

acquired	alive	chronic	~~ill~~	malign
mild	minor	robust	susceptible	tense(d)

1. The opposite of *healthy* is ill .
2. The opposite of *major* is _____ .
3. The opposite of *dead* is _____ .
4. The opposite of *acute* is _____ .
5. The opposite of *severe* _____ .
6. The opposite of *benign* is _____ .
7. The opposite of *congenital* is _____ .
8. The opposite of *resistant* is _____ .
9. The opposite of *relaxed* is _____ .
10. The opposite of *delicate* is _____ .

1.3 Some Commonly Encountered Medical Conditions

Alzheimer's	acquired deafness	aphasia	~~apraxia~~	asthma
back pain	catatonia	cerebral palsy	cerebrovascular accident (CVA)	chronic obstructive pulmonary disease (COPD)
cystic fibrosis	dementia	dysarthria	dysphagia	fatigue
juvenile arthritis	lymphoedema	muscular dystrophy (MD)	obsessive-compulsive disorder	paraplegia (PARA)
psychosis	repetitive strain injury (RSI)	sciatica	stress incontinence	stuttering

Exercise

Here are some conditions commonly encountered in occupational therapy, physiotherapy or speech and language therapy. Read the 25 descriptions which follow and decide which word from the table above is described in each case. The first one has already been done for you as an example.

1. apraxia = inability to carry out a complex or skilled movement due to deficiencies in cognition
2. _____ = a group of chronic respiratory disorders characterized by the restricted flow of air into and out of the lungs
3. _____ = a group of motor disorders resulting in loss of muscular coordination and muscle control; caused by damage to the motor area of the brain during foetal life, birth and infancy
4. _____ = a swallowing disorder often depicted by difficulty in oral preparation, pharyngeal transit, and/or oesophageal motility
5. _____ = a rheumatic condition causing inflammation, swelling and stiffness in the joints
6. _____ = most often the result of poor posture, an injury or overuse
7. _____ = occurs when the bladder leaks if put under pressure, perhaps by a cough or a sneeze, or during strenuous activity
8. _____= difficulty in speaking characterized by frequent repetition or prolongation or by frequent hesitations or pauses that disrupt the rhythmic flow of speech
9. _____ = causes recurrent breathlessness, wheezing and difficulty in breathing
10. _____ = occurs when the normal blood flow to the brain is suddenly interrupted or blocked
11. _____ = total or partial loss of the ability to use or understand language; usually caused by a stroke, brain disease, or injury
12. _____ = a disabling neurological disorder that may be characterized by memory loss, disorientation, hallucinations, loss of ability to read, write, eat, or walk, and finally dementia
13. _____ = caused by repetitive movement leading to muscular pains or problems with nerves, ligaments and joints in the upper limbs
14. _____ = a hereditary, chronic, progressive disease characterized by excessive mucus secretion clogging the lungs and pancreas
15. _____ = a motor speech disorder that results from weakness, paralysis or lack of coordination
16. _____ = a condition due to blockage or damage of the lymphatic system resulting in accumulation of lymph fluid in tissue
17. _____ = a progressive mental disorder that affects memory, judgement and cognitive powers

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18. _____ = nerve inflammation characterized by sharp pains along the area from the hip down to the back of the thigh and surrounding area
19. _____ = a motor abnormality usually characterized by immobility or rigidity
20. _____ = an anxiety disorder characterized by recurrent uncontrollable thoughts and/or irresistible urges to engage repetitively in an act
21. _____ = paralysis of the spine affecting the lower portion of the trunk and legs
22. _____ = state of exhaustion or loss of strength and endurance; decreased ability to maintain a contraction at a given force
23. _____ = a major mental disorder that can cause extreme personality disorganization, loss of reality orientation and inability to function appropriately in society
24. _____ = an inherited degenerative neuromuscular disorder characterized by progressive muscle weakness and atrophy
25. _____ = loss of hearing that occurs or develops some time during the lifespan but is not congenital

Additional info online

Active Vocabulary: Disease and Illness II

Are you familiar with the following words that were used in the exercise? Please write down the equivalent English terms.

- Angstneurose = _____
- anstrengende Aktivität = _____
- Atemlosigkeit, Atemnot = _____
- Ausdauer = _____
- Desorientiertheit, Verwirrtheit = _____
- Entzündung = _____
- Gedächtnisverlust = _____
- Halluzination = _____
- Haltung = _____
- Husten = _____
- (Laut-)Dehnung = _____
- Lymphe, Lymphflüssigkeit = _____
- motorische Störung = _____
- Niesen = _____
- Paralyse, (vollst.) Lähmung = _____
- pfeifende, keuchende Atmung = _____
- psychische Störung = _____
- Schlaganfall = _____
- Schwellung = _____
- Steifheit, Unbeweglichkeit = _____

- Stimmungsschwankungen = _____
- Überbeanspruchung = _____
- Unvermögen, Unfähigkeit = _____
- Verletzung = _____

1.4 Health Professionals

Additional info online

Physicians and nurses are probably the medical practitioners best known to the general public.

Physicians work in primary care or are hospital-based. In the USA, there are two types of physicians: M.D.s – medical doctors (with a degree as Doctor of Medicine), and D.O.s – osteopaths (with a degree as Doctor of Osteopathy). The training of D.O.s is similar to that of M.D.s though they are specialized in the musculoskeletal system and place a strong emphasis on a holistic perspective.

Nurses care for people with actual or potential health problems in hospital, nursing home and community. In the United Kingdom there are four main branches of nursing: adult nursing (registered general nurse – RGN), children's nursing (registered sick children's nurse – RSCN), mental health nursing (registered mental nurse – RMN) and learning disability nursing (registered nurse for the mentally handicapped – RMHN). In the USA, the various types of nurses include licensed practical nurses (LPNs), registered nurses (RNs) and advanced practice nurses (APNs).

Midwives support mothers and their families throughout the childbearing process, carry out clinical examinations and provide health and parenting education, sometimes together with other health and social care services. Midwifery is an independent university degree programme or a special training course for registered nurses.

Health visitors are registered nurses or midwives in the United Kingdom with special training in the assessment of the health needs of individuals, families and the community. In particular, they have a major support role for families with pre-school children.

Health care assistants (HCAs) assist health care professionals like nurses and midwives in hospitals, clinics and community nursing. They help with basic patient care like washing and dressing, feeding, toileting and bed making.

In the US health care system there is a general trend towards saving costs by relying more heavily on nonphysician health care professionals, who may function as direct primary health care providers and prescribe medications, albeit (in most US states) under the direction and supervision of an M.D. or D.O. For example, **physician assistants** (PAs) were introduced in the US health care system in the 1960s as medical personnel trained to provide treatment and care for primary health care ailments. They handle technical procedures and exercise some degree of medical responsibility. **Nurse practitioners**

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(NPs) are APNs with specialized training who conduct physical examinations, prescribe medication, diagnose and treat illness, interpret lab tests and counsel patients on health care options.

40 There are many more health-related occupations, most of which are classified under the term "allied health professions" (AHPs), like occupational therapists, physiotherapists and speech and language therapists.

Note

In the United Kingdom and many other Commonwealth countries (excluding Canada), the M.D. is a higher doctoral degree, comparable to the German Dr. med. An M.D. typically involves either a number of publications or a thesis and is examined in a similar fashion to a Ph.D. (Doctor of Philosophy) degree. In Canada, the M.D. is the basic medical degree required by medical practitioners.
In the USA, there are two basic medical degrees allowing the practice of medicine, i.e. the M.D. and the D.O. It is important to note that in North America, medical degrees are not equivalent to research doctorates (Ph.D.) as they do not require the writing of a doctoral dissertation. In the USA and Canada, the M.D. is therefore a professional degree and not equivalent to a Ph.D. in medicine.

Exercise

What is the job description of a physician assistant? What kind of training does a health visitor have? What does a nurse practitioner do? Do some research on the internet to find out more.

Exercise: Medical Specialities

According to the Miller-Keane Encyclopedia & Dictionary of Medicine, Nursing, & Allied Health (2003) there are 119 different specialities or sub-specialities that physicians can be trained in. Physicians work in one or more of several specialities.

Match each type of physician with the right job description. The first one has already been done for you as an example.

anaesthesiologist	dentist	emergency physician	~~general practitioner (GP)~~
geriatrician	obstetrician and gynaecologist (ob/gyn)	ophthalmologist	orthopaedist
otorhino-laryngologist (or ENT specialist)	paediatrician	psychiatrist	surgeon

1. The general practitioner (GP) assesses and treats a wide range of conditions, ailments, and injuries as the first point of contact for ill people.
2. The _____ is specialized in the diagnosis and treatment of mental health problems.
3. The _____ is concerned with the health of infants, children, and teenagers.
4. The _____ is specialized in disorders of bones, joints and associated structures.
5. The _____ treats injury, disease, and deformity through operations.
6. The _____ is specialized in resuscitation, medical emergencies, pain relief, and trauma management.
7. The _____ administers drugs or agents to abolish the sensation of pain in surgical patients.
8. The _____ is specialized in the treatment or study of diseases and ailments of old people.
9. The _____ is responsible for general medical care for women, but also provide care related to pregnancy and the reproductive system.
10. The _____ is specialized in the diagnosis, medical treatment, and surgical treatment of eye diseases.
11. The _____ diagnoses, treats and restores the teeth, oral cavity and associated structures.
12. The _____ is specialized in disorders affecting the ears, nose, and throat.

1.5 Types of Health Care Systems

Particularly in advanced welfare states, health care systems are faced with the idealistic expectation that the whole population has **equal access to health services** that provide high-quality care and remain financially viable. The most obvious distinction in health care systems worldwide can be made between public and private health care systems.

Public Health Care Systems

Public health care systems embody the notion that the state is responsible for providing its citizens with health care treatment regardless of whether they have the means to pay for it or not (i.e., **universal coverage**). Two main types of public health care systems are found in Europe. In both, the contributions made by all contributors are pooled and services are provided only to those who need them.

Firstly, there are the **social health insurance-based systems** (SHI), found in countries like Germany, where employees and their families are insured by

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the state. In an SHI system, contributions come from workers, the self-employed, enterprises and government.

Secondly, there are **tax-based systems**, found in countries like the United Kingdom (UK) and Scandinavia, where all residents of a country are members of a state insurance programme. In tax-based systems, general tax revenue is the main source of financing, so that users in this system only pay a small fee for medical services or even none at all. The government is the primary agent responsible for providing or purchasing health services. In general, the tax-based system has been highly criticized because of its long waiting lists for non-emergency services (elective plastic surgery, etc.) and the lack of measures in place for quality assurance.

In most countries with a public insurance system, a parallel private system is allowed to operate. This is often referred to as **two-tiered health care**. Since the 1990s, both types of public insurance system have tried to contain costs and adapt to recent demographic developments, such as the ageing population, by assuming more market-like features such as increased competition among health care providers and raising private out-of-pocket payments.

Private Health Care Systems

In private health care systems health services are delivered on the basis of a **fee-for-services plan**. The insured individual pays a monthly premium personally or through an employer, so that at the time of hospitalization or other specific care the total amount of the bill need not be paid by the user. Instead, the insurance company will be responsible for paying most of the bill, although there is often an excess. This type of system is based on the general assumption that the user is financially capable of paying for the insurance fee, an obvious drawback for people who are not in that position.

However, health insurance is often only widely available at a reasonable cost through an employer-sponsored **group plan**, leaving unemployed and self-employed individuals at a disadvantage.

In their pure form private enterprise systems are rare as most countries try to provide some basic form of health service to their citizens. The United States of America (USA), for example, uses a private health care system for the majority of its citizens with residual public services only for specific needy groups within the population.

Active Vocabulary: Odd One Out

Decide which of the words listed below is *not* a synonym for the word used in the text. If you do not know the meaning of a word, please look it up in a general dictionary. One has already been done for you as an example.

viable (line 3)	feasible – tenable – calculable
distinction (line 4)	differentiation – discrimination – distinctiveness
to embody (line 7)	to contain – to ingrain – to include
regardless (line 8)	remorseless – irrespective – albeit
means (line 9)	capacity – measures – funds
lack (line 25)	absence – abundance – want
to contain (line 28)	to border – to limit – to curb
feature (line 30)	property – statement – characteristic
drawback (line 36)	~~penalty~~ – disadvantage – handicap
residual (line 43)	remnant – remaining – remote

Active Vocabulary: Health Care Systems I

What are the English equivalents of the words listed below? They are all used in the above text.

Additional info online

- Einzelleistungsvergütung = _____
- Gebühr = _____
- Gesundheitssystem, Gesundheitswesen = _____
- Selbstbehalt = _____
- sozialversicherungsbasiertes System = _____
- steuerbasiertes System = _____
- Versicherungsbeitrag, Prämie = _____
- Zahlung aus eigener Tasche, Zuzahlung = _____
- zweistufig = _____

Questions

1. **Who is generally eligible for health care services in a public health care system?**
2. **What is the difference between the two main types of public health care systems in Europe?**
3. **What does "two-tiered health care" mean?**
4. **How are private health care systems organized?**

Discussion

What are the advantages and disadvantages of public health care systems compared with private health care systems?

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1.6 The Health Care System of the UK: The National Health Service (NHS)

Health Care in the UK

The National Health Service (NHS) was created in 1948 as a **public health insurance scheme** funded through general taxation and National Insurance contributions. All UK citizens – and also everyone living lawfully and on a settled basis in the UK – are automatically members of the NHS and thus covered for most medical requirements with a common level of cover and set premium. The state covers the premiums for people with no incomes. The NHS determines how much money to spend each year on health care by utilizing a capitation method for general physicians and a fee-for-service system for specialists.

A small **private health insurance** market exists, too, accounting for 11% of the population. Private health insurance is paid for voluntarily by individuals or their employers.

Advantages and Disadvantages of the NHS

The obvious advantages of this type of health care system are that the **premiumsare low** compared to those in other countries, e.g. Germany, and that all members of the NHS are entitled to receive **free medical services**, including basic dental treatment and provision of glasses and hearing aids. On the other hand, the system is put under considerable strain as it tries to balance a large number of insurance holders with **scarce financial resources**. As a result, there have been constant public debates since the late 1990s about the need to slash waiting lists for referrals to hospital or consultant-led services (e.g., for planned surgery like knee replacement or tonsil removal).

Organizational Structure of the HNS

Since the late 1990s the NHS has undergone some fundamental restructuring. Due to the devolution process that gave powers over a number of areas, including health and health services, to national parliaments and assemblies, the NHS is now **run independently in England, Scotland, Wales and Northern Ireland**. The overall structure of the different national services is similar, however. In England, the responsibility for running the NHS is shared by the Department of Health, Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs).

The **Department of Health** is responsible for securing sufficient funds from overall government spending to finance NHS services and for setting national standards of care.

More than 300 **primary care trusts (PCTs)** covering all parts of England control 80% of the total NHS budget. It is their task to assess local health needs in the area they are responsible for and to commission the services necessary to meet those needs, e.g. GP practices, hospitals and dentists. The PCTs work with local authorities and other agencies that provide health and social care at the local level. For example, PCTs must make sure there are enough services for people in their area and that these are accessible to patients, including hospitals, dentists, mental health services, ambulances, pharmacies and opticians.

Furthermore, they are responsible for the successful cooperation of health and social care systems to improve client care.

As a link between the NHS and the Department of Health, 10 **strategic health authorities (SHAs)** are responsible for managing and setting the strategic direction of the NHS locally. They monitor how well PCTs and other NHS organizations in their area are performing and ensure that local health service plans duly reflect national priorities.

There is an important distinction in the delivery of services in the UK health care system between primary care (i.e., community-based services) and secondary care (i.e., hospital-based services).

Primary Care

Primary care is concerned with the **treatment of routine injuries and illnesses** and the provision of **preventive care**. For most people it is their first point of contact with the NHS. All citizens must be registered with one of the local doctors' surgeries, which are typically run by three to six **general practitioners** (GPs) as GP principals or partners in practice. These doctors are usually joined by a team of nurses, health visitors and midwives, as well as a range of other health professionals such as physiotherapists and occupational therapists. In some areas there are plans to replace these doctors' surgeries with larger **medical centres**. Patients have the right to choose which health care professional they want to receive primary medical services from, but can also normally see any other doctor within their surgery, especially if they need an appointment quickly. Their general practitioner functions as a **"gatekeeper"** who determines if and when they need a referral to a hospital for tests or treatment or need to see a consultant with specialized knowledge. Other important services providers in primary care are **pharmacists**, **opticians** and **dentists**.

Secondary care

Secondary care, i.e. **emergency or elective care**, is usually provided by an NHS hospital. Hospitals are managed by **NHS trusts** (acute trusts and foundation trusts) and their services are commissioned or purchased by primary care trusts. Planned specialist medical care or surgery (e.g., hip replacement or kidney dialysis) usually requires referral from a GP. Elective care services are often delivered in **day surgeries**, where patients are treated with keyhole surgery, for example, and can go home on the same day, or in **treatment centres**, which specialize in streamlined surgery and diagnostic tests in particular in orthopaedics and ophthalmology. In emergency care or Accident and Emergency (A&E), patients are admitted to hospital as a result of an accident or trauma and require emergency treatment. The **NHS ambulance trusts** are the local organizations responsible for responding to 999 calls and transporting patients to hospital in an ambulance.

Other examples of secondary care services include specialist services for mental health, learning disability and older people. Specialist mental health care is normally provided by **NHS mental health trusts** in cooperation with local council social services departments. The services provided range from psychological therapy to very specialist medical and training services for people with severe mental health problems such as severe anxiety problems or psychotic illness.

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Care trusts (the numbers of which are still small) are set up when the NHS and local authorities agree to work closely together, usually where it is felt that a **closer relationship between health and social care** is needed or would benefit local care services. Their aim is to combine health and social care services under a single organizational structure to provide joined-up social care, mental health services or primary care services for people whose needs are more complex.

With approximately 1.3 million staff, the NHS is the largest employer in Europe. As nearly all hospital doctors, nurses and other hospital-based health professionals are employed by the NHS and work in NHS-run hospitals, the NHS is by far the most important single employer for health professionals in the United Kingdom.

Note

The word "surgery" has a multitude of meanings, in particular in British English: Behandlungsraum, Chirurgie, Operation, Sprechzimmer (BE), Arztpraxis (BE), Sprechstunde (BE).

Additional info online

Active Vocabulary: Health Care Systems II

The English equivalents to these German words are used in the text. What are they?

- Abdeckung, Versicherungsschutz = _____
- ambulante Sprechstunde = _____
- berechtigt sein zu, Anspruch haben auf = _____
- finanzieren = _____
- Finanzmittel = _____
- Gemeindesozialamt = _____
- Kommunalbehörden = _____
- Krankenwagen = _____
- medizinische Grundversorgung = _____
- Notruf = _____
- öffentliches Krankenversicherungsprogramm = _____
- Praxisteilhaber = _____
- Pro-Kopf-Pauschale = _____
- psychische/psychiatrische Versorgung = _____
- Sozialversicherungsbeiträge = _____
- Termin = _____
- vereinigt, zusammen gelegt = _____
- Versicherungsbeitrag, -prämie = _____

Questions

1. **Which type of health care system does the UK have?**
2. **Is the NHS responsible for the whole of the UK?**
3. **How is the primary health care sector organized in England?**
4. **Which types of trust exist in England and what are they responsible for?**

Exercise

Fill in the gaps by using appropriate words from the above text.

The _____ (1) (NHS) is the biggest employer of health professionals in the UK. _____ (2) are the local organizations at the centre of the NHS. They follow the national strategic directions set by the _____ (3) and report directly to their local _____ (4) , which is responsible for improving and monitoring their services. NHS patients are required to register with a local _____ (5) of their choice. Hospitals are responsible for providing _____ (6) and _____ _____ (7) care. _____ (8) may be admitted either as inpatients or day case patients, or they may attend an _____ _____ (9) consultation or clinic. The services provided by Mental Health Trusts range from _____ (10) to very specialist care for people with severe _____ (11) problems.

Discussion

"The NHS is recognized as one of the best health services in the world by the World Health Organization but there need to be improvements to cope with the demands of the 21st century" (www.nhs.uk/Aboutnhs/howthenhsworks/Pages/HowtheNHSworks.aspx)

What could this statement be referring to? Discuss possible advantages and disadvantages of the UK health care system.

1.7 Health Care in the USA

Health Care in the USA

In recent decades, the political, economic, societal and ethical implications of on-going developments in the US health care system have been widely discussed. The organization of health care in the United States differs significantly from, for example, the British health care system, since it is heavily influenced by the private insurance sector and characterized by a rising percentage of the population that is either underinsured or without health insurance altogether. Although the US health care system also has a public sector, it is by far outweighed by private medical insurance, thus defining the US as **a private or insurance-based health care system**.

The Private Health Care Sector

In the US, health care has always been considered the responsibility of the individual. The political conviction that public health programmes funded and administered by the government would only serve to pamper citizens and quench initiative influences the philosophy adopted by the US health care system. It is for this reason that health insurance has remained largely the responsibility of employers and employees.

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The Indemnity Health Insurance Plan

The most popular model of health coverage used to be the indemnity health insurance plan where employer and employee paid a **monthly premium** to a selected insurance company. In the event of illness, payment was made on a **fee-for-service reimbursement basis**, that is, the patient paid the health care provider (e.g., hospital, physician, pharmacy or nursing home, etc.) for the treatment "out of pocket" and was later reimbursed 80% of the cost by the insurance company. An example of this type of plan is **Blue Cross/Blue Shield**. For various reasons (e.g., increasing elderly population, large number of older patients, health care inflation, etc.) the cost of health care insurance rose dramatically in the 1970s and 1980s. This, in turn, caused employers to increase deductibles and co-payments in the fee-for-service plans, ultimately making employees financially responsible for a larger part of the health care premiums.

Characteristics of Managed Care

The introduction of managed care, a system of health care delivery that tries to reduce costs by setting predetermined **"usual, customary and reasonable" (UCR) fees** for provider reimbursements and by regulating access to health care rapidly became very successful in the US private health care sector. In fact, only a minority of the insured citizens today are enrolled with indemnity plans.

There are several different types of managed care plans, for example, Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Exclusive Provider Organizations, Point of Service Plans, Physician Hospital Organizations and Integrated Health Care Systems. All share a host of **common features**.

Firstly, managed care plans create **networks of health care practitioners and health care facilities** providing primary and specialized care to plan members on the basis of a contract, that is, so-called **contracted providers**. In a capitation contract the provider receives a set monthly amount for each enrolee and, in return, agrees to provide health care services for that set amount. The method of **capitation** (paying a per capita rate to the provider who is then responsible for delivering all health services required by the patients) is another way to counter spiralling costs.

Secondly, the primary care provider (usually a physician) often functions as a **"gatekeeper"** or **"single point of entry"** and it is he or she who decides whether a patient needs to be referred to a specialist or other contracted service provider or not. The physician's decision should take into consideration which patients are at greatest risk for health-related problems and in greatest need of services.

Thirdly, **utilization management techniques** or **treatment planning procedures** are commonly used to ensure that medical resources are not unnecessarily used. Managed care organizations also use **practice guidelines** to determine whether specific measures are appropriate and medically necessary. **Case managers** are employed to identify patients that might require high cost care and ensure that resources are used in a cost-effective way.

Fourthly, managed care organizations apply very **strict regulations** for the **authorization** of treatment as well as the settling of patient claims.

HMO and PPO – The Most Common Types of Managed Care Plans

Health Maintenance Organizations (HMOs) are usually **owned by employers and health insurance companies** who then pay contracted providers for their health care services. The most familiar type of HMO is the **Independent Practice (or Physician) Association**, where independent practitioners in private practice are directly contracted by the HMO. (Other HMO types are the Group Model, the Network Model and the Staff Model, although various combinations of these four models are becoming increasingly popular). On the other hand, there are also those HMOs that directly employ physicians and other health care professionals, or even run the actual health care facility, although these are less common.

In general, patients can only choose to receive services from the specific providers contracted by the HMO. HMOs are primarily financed by monthly premiums paid by clients or employers, though patients are often additionally charged a small fee at the time services are required. The services provided by HMOs include primary care, prevention and education. HMOs also provide services on an outpatient basis when possible: an effective way to keep costs down.

Preferred Provider Organizations (PPOs), not exclusively under the ownership of employers and health insurance companies but also of physicians or hospital chains, **combine elements of the traditional indemnity health insurance plans and the HMO models**. PPOs are not prepaid plans, that is, they bill employers or insurances companies independently for the services provided and they attempt to keep costs down by following a fixed fee schedule.

The main difference between PPOs and HMOs is the **freedom that PPO clients have in choosing a physician**, especially viable when willing to pay more. In PPOs, referrals to other health care providers need not be authorized by a primary care physician and there is no capitation (i.e., fixed per case payment). Given a choice, employees generally prefer to enrol for coverage with a PPO rather than an HMO.

The Public Insurance Sector

In addition to the work-related (i.e., private) health insurance systems there are several government-based (i.e., public) insurance programmes.

Medicare

Medicare, founded in 1965, is a health insurance programme offered by the US federal government to **most people over the age of 65** (i.e., retirement age) and to **younger people with disabilities**. According to the U.S. Census Bureau, it currently insures 13.7% of the US population, providing health services for acute illnesses.

Medicare is divided into two segments: a mandatory Part A for hospital services and an optional Part B for physician and outpatient hospital services, 80% of these costs being refunded by Medicare. **The hospital programme** (i.e., Part A) covers inpatient care, home health care, hospice

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care, and outpatient skilled nursing care. The **medical programme** (i.e., Part B) covers physician fees and the majority of "other-related" outpatient care. Employees and employers each contribute an income tax to support the hospital fees (i.e., Part A). Part B, on the other hand, is funded through monthly premiums paid by the beneficiaries and through general taxes.

Medicaid

Medicaid is funded jointly by the federal and state authorities and is available for people of all ages who cannot afford proper medical care because their **income** is **too low**. Medicaid is the largest health insurer in the US in terms of eligible beneficiaries, covering medical services and long term care for over 38.1 million people (i.e., 13% of the population), according to the 2005 U.S. Census Bureau figures. However, not all poor citizens are automatically entitled to Medicaid; rather, **federally defined criteria** such as advanced age, blindness, disability, or membership in a single-parent family with dependent children need to be met first in order to receive Medicaid coverage.

A Critical Look at the System

According to the U.S. Census Bureau, **46.6 million people** (i.e., 15.9% of the US population) were **without health insurance coverage** in 2005 – individuals who are either not poor enough to receive Medicaid, cannot afford health insurance, or where the insurance companies refuse to insure them because they suffer from cost-intensive diseases. This percentage is significantly higher than that of other industrialized nations. Additionally, **many people are underinsured**.

A recent study comparing health care services in the US with those in Australia, Canada, New Zealand, Britain and Germany found out that Americans needed to make **larger out-of-pocket payments** when they became ill, that more than half did **not receive the care required** because of costs and that more than one-third endured **mistakes and disorganized care** when treated (Anderson et al. 2005). Despite the billions of dollars that the US spends on health care it has the highest **infant mortality** rate and the lowest **life expectancy** rate among these industrialized nations.

It remains to be seen whether future US governments will successfully tackle the serious problem of underinsured and uninsured segments of the population, and also, to what extent features of the managed care system will be adopted by other health care systems.

Additional info online

Active Vocabulary: Health Care Systems III

The English equivalents to these German words are used in the text. What are they?

- Anspruch = _____
- Anspruchsberechtigte/r, Bezugsberechtigte/r = _____
- Antragsteller, Bewerber = _____
- berechtigt, förderungswürdig = _____
- erstatten = _____
- feste Gebührenordnung = _____

- häusliche Krankenpflege = _____
- Gesundheitseinrichtung = _____
- in Rechnung stellen = _____
- Kostenerstattung = _____
- Leistungsanbieter, -erbringer = _____
- Pflege im Hospiz = _____
- Praxisleitlinie = _____
- sich einschreiben, sich anmelden = _____
- stationäre Pflege = _____
- überweisen an = _____
- Versicherungsgesellschaft = _____

Questions

1. **What was the reason for the introduction of managed care?**
2. **How is managed care characterized?**
3. **Which measures do managed care organizations apply to keep costs down?**
4. **How does an HMO work?**
5. **Why are PPOs generally more popular with employees?**
6. **Who is eligible for Medicare?**
7. **Which health services are covered by Medicare?**
8. **Who is entitled to Medicaid?**
9. **Why do some US citizens have no health insurance at all?**
10. **What are the characteristic features of medical services in the USA according to the study by Anderson et al. (2005)?**

Exercise

Fill in the gaps by using appropriate words from the above text.

The health care system of the USA is defined as a _____ (1) health care system. As such, health insurance is mainly organized by _____ (2) for their _____ (3). In fee-for-service plans enrolees need to pay regular _____ (4) as well as _____ (5) and _____ (6) for health services rendered. The most common form of health insurance in the US is _____(7). The most important types of managed care are _____ (8) and _____ (9). Health professionals who work for managed care plans are called _____(10). They are paid a _____ (11) rate for their services. Members of a managed care plan need to see their _____ (12), who is responsible for referring them to specialist care, e.g. at a hospital. Although about 80 million US citizens are eligible to _____ (13) health insurance, there is also a significant percentage of _____ (14) people.

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Discussion

1. What would be the possible advantages and disadvantages of introducing a government-based health care system in the USA? Which factors would facilitate or hinder such a step? Before you start a group discussion on the topic, decide who wants to represent which viewpoint so that the participants can take some notes of their main points.
2. The idea of prospective payment central to managed care plans initiated the development of DRGs (diagnosis-related groups) to classify patients in the USA. Another example is the introduction of medical technology assessment (MTA), based on explicit cost-effectiveness and cost-benefit studies, as a tool for health policy, which was devised in response to a need for more information for policymakers. Considering the great attraction such concepts have had for health researchers and policymakers in Europe, will European health care systems ultimately be organized like managed care plans? Make a list of pros and cons before you start discussing the topic in a group.

1.8 Health Services in the USA

Exercise

adult day care	age-integrated housing	early intervention	home health care
hospice programme	Meals on Wheels	outreach services	psychiatric rehabilitation services
~~residential care facility~~	sheltered housing	skilled nursing facility (SNF)	

The table above lists some important types of health care services, facilities and programmes. Read the descriptions which follow and decide which word from the table is described in each case. The first one has already been done for you as an example.

1. residential care facility = group living arrangements that are designed to meet the needs of people who need assistance with daily living activities, such as bathing, dressing, toileting, urinary or bowel incontinency care, but do not require nursing facility services

2. _____ = a nutrition programme which delivers meals to the home of individuals, usually seniors aged 60 or older, who are unable to purchase or prepare meals themselves

3. _____ = a combination of services incorporating social, educational, occupational, behavioural and cognitive interventions aimed at long-term recovery and maximization of self-sufficiency

4. _____ = comprehensive community-based services for little children (from birth to age 3) with

developmental vulnerability or delay and their families to enhance child development and promote adaptive family functioning

5. _____ = a community that is not restricted to one particular age group, i.e. elderly people, but where people of all ages live together
6. _____ = services that seek out and identify hard-to-reach individuals and assist them in gaining access to needed health care and social services
7. _____ = for clients who no longer need acute care in hospitals, but still need continued professional nursing care to reach their optimal level of functioning within the facility or in their homes
8. _____ = daily structured programme in a community that is designed to meet the needs of adults with functional impairments by providing health, social, and related support services in a protective setting
9. _____ = provides care and comfort for terminally ill clients and for their families
10. _____ = living arrangements that provide structure and supervision for individuals who do not require institutionalization but are not fully capable of independent living
11. _____ = provision of medical and nursing services in the individual's home ordered by a doctor

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Additional info online

1.9 The German Health Care System

Exercise

Here is some health care vocabulary particularly helpful to describe the health care system in Germany. Please match the German expressions with their English equivalents. The first one has already been done for you as an example.

1. Arbeitnehmeranteil	A. benefits catalogue
2. Arzneimittel	B. Book V of the Social Code
3. Bundesministerium für Gesundheit	C. capitation fee
4. demographischer Wandel	D. complementary insurance
5. Einkommensgrenze	E. demographic change
6. freie Kassenwahl	F. employee's contribution
7. freiwillige Krankenversicherung	G. Federal Ministry of Health
8. gesetzliche Krankenversicherung	H. guideline on remedies
9. Gesundheitsvorsorge	I. home nursing care
10. häusliche Krankenpflege	J. hospital stay
11. Heilmittelrichtlinie	K. level of income
12. Kopfpauschale	L. long-term care insurance
13. Krankengeld	M. Medical Devices Act
14. Krankenhausaufenthalt	N. open enrolment
15. Kur	O. pharmaceutical
16. Leistungskatalog	P. prescription
17. Medizinproduktegesetz (MPG)	Q. preventive health care
18. pflegebedürftig sein	R. quarterly billings
19. Pflegeversicherung	S. reconvalescence treatment
20. Quartalsabrechnung	T. referral
21. Rezept, Verschreibung	U. sickness benefits
22. Schutzimpfung	V. solidarity principle
23. Solidaritätsprinzip	W. statutory health insurance
24. Sozialgesetzbuch V	X. to be in need of nursing care
25. Überweisung	Y. vaccination
26. Zusatzversicherung	Z. voluntary health insurance

Simulation Task

Imagine meeting a colleague from another country at a conference who has never been to Germany before and wants to find out about your health care system. Get together with a partner and practise asking and answering questions about health care in Germany.

Exercise/Simulation Task

Imagine being invited to give an overview on the German health care system to an audience. Choose your own scenario (audience, context, length of talk, etc.) and plan your talk accordingly.

Alternatively, write a short essay about health care in Germany (500 – 800 words).

Simulation Task

Imagine being invited to a panel discussion on the future role of therapists in a changing health care system.
Think about your own viewpoint and prepare some statements (see the Appendix for useful phrases for discussions).
Alternatively, you can adopt one of the following positions and represent it in the discussion:

a) You are not seriously worried about the current health care deficit. You envisage a bright future for therapists: considering the ageing population the profession has an ever-growing clientele. In the future your profession could also concentrate more on the area of health promotion, instructing people to keep in shape and not develop certain health problems.
b) You can understand that there is a need to reduce public spending on costly treatments. You are able to make some suggestions on how money can be saved without introducing strict budgets for the therapeutic treatment of certain diseases.
c) You are totally opposed to any limitation of a patient's budget for therapeutic treatment. You illustrate your point by giving some examples of patients with diseases where treatment was expensive but beneficial.

Unit 2: Body Parts and Body Functions

2.1 Basic Anatomical Terms

Additional info online

2

Exercise

Find the 35 anatomical terms hidden in the letters below. 13 read across, 16 read down and 6 diagonal. The clues listed beneath will help you to find all the words. The first word has been found for you as an example.

C	H	I	N	O	W	A	I	S	T	E	R	X
R	A	T	K	K	I	M	P	E	L	V	I	S
O	T	O	E	I	N	R	O	C	A	L	F	B
S	H	O	U	L	D	E	R	L	B	R	L	U
P	U	E	K	Y	P	N	E	A	D	O	A	T
A	M	S	U	L	I	V	E	R	O	A	N	T
L	B	O	H	I	P	I	L	Y	M	N	K	O
M	O	P	F	T	E	N	B	N	E	K	S	C
U	T	H	R	O	A	T	O	X	N	L	P	K
B	R	A	I	N	R	A	W	S	T	E	I	S
I	S	G	O	G	L	E	T	U	E	R	N	D
H	H	U	N	U	X	C	H	E	S	T	E	E
E	I	S	T	E	L	L	I	E	V	K	S	E
E	N	W	R	I	S	T	G	M	A	N	I	L
L	P	A	L	A	T	E	H	O	M	D	E	N

Here are the German meanings of the words hidden in the crossword puzzle. Match these to the English definitions listed below.

a) Augenlid	b) Bauch	c) Becken	d) Brust	e) Daumen	f) Ellenbogen	g) Ferse
h) Flanke	i) ~~Fußknöchel~~	j) Gaumen	k) Gehirn	l) Gesäß	m) Handgelenk	n) Handinnenfläche
o) Haut	p) Hüfte	q) Kehle	r) Kehlkopf	s) Kinn	t) Knie	u) Leber
v) Luftröhre	w) Nase	x) Niere	y) Oberschenkel	z) Ohr	aa) Schienbein	bb) Schulter
cc) Speiseröhre	dd) Stirn	ee) Taille	ff) Wade	gg) Wirbelsäule	hh) Zeh	ii) Zunge

1. the joint connecting the foot to the leg __i__
2. the joint connecting upper arm and forearm ___
3. a part of the face above the eyes ___
4. the top part of the leg above the knee ___
5. the joint linking the hand to the forearm ___
6. the front part of the neck ___
7. the organ that cleans alcohol and toxins from the blood ___
8. the joint in the middle of the leg ___
9. the inner surface of the hand ___

10. either side of the body below the waist and above the thigh ___
11. the part of the body between the neck and the abdomen ___
12. enclosed within the skull ___
13. the organ for hearing ___
14. the area between the chest and the hips ___
15. the protruding part of the lower jaw ___
16. the side between ribs and hip bone ___
17. the short thick digit of the human hand ___
18. the roof of the mouth ___
19. one of the digits of the foot ___
20. the joint connecting the arm with the torso ___
21. an important organ of speech ___
22. the axis of the skeleton ___
23. the cover of the eye ___
24. the passage from the larynx to the lungs ___
25. the front part of the leg below the knee ___
26. the entrance to the respiratory tract ___
27. located between the hip bones ___
28. the organ that produces sound ___
29. narrow part between the ribs and the hip ___
30. the posterior part of the human foot ___
31. the part of the human body that you sit on ___
32. the tube that leads from the throat to the stomach ___
33. the back part of the lower leg ___
34. the protective cover of the body ___
35. a bean-shaped organ that filters wastes ___

2.2 The Anatomy of the Human Body

Exercise

Complete the sentences below using the words from this table. Every word appears only once. The first one has already been done for you as an example.

abdomen	further	mouth	supine
anatomical position	head	near	through
anterior	horizontal	nearer	to the side of the body
back	knee	nose	together
breastbone	lateral	parallel	trachea
chest	left	perineum	~~trunk~~
down	longitudinal	perpendicular	upper
foot	lower	posterior	upper limb
forehead	lower limb	prone	upright
forwards	median	right	vertebral column
front	midline	straight forward	vertical

Additional info online

Note

The Appendix provides an overview of directions and planes of reference.

2

The human body consists of a head, a trunk and limbs. The trunk (1) is formed by neck, thorax and abdomen. The lower part of the _____ _____ (2) is the pelvis, the lowest part of the pelvis is the _____ _____ (3). The _____ (4) forms the central axis of the trunk and its cervical part supports the _____ _____ (5). The _____ (6) is formed by the arm, forearm and hand; the _____ (7) by the thigh, leg and foot.

For the description of human body structures and their positions, the body is assumed to be standing _____ (8) with feet _____ _____ (9) and the head and eyes looking _____ _____ (10). The arms are kept _____ (11) with palms facing _____ (12). This position is called the _____ _____ (13) and human body structures are always described using this position as a baseline and standard, even when the body is lying ___ _____ (14). If the body is lying face up, this is referred to as _____ (15), if it is lying face down, the body is in a _____ (16) position.

There are three types of primary or cardinal planes that pass _____ _____ (17) the body: sagittal, coronal and transverse. The sagittal plane is also known as the _____ (18) or mid-sagittal plane. It is the imaginary vertical, _____ (19) axis right through the middle of the human body from front to back and divides the human body into _____ (20) and _____ (21) halves. Planes passing _____ (22) but not in the mid-line are called para-sagittal planes. Medial means towards the _____ _____ (23) of the body, whereas _____ (24) structures lie further away from the midline. Intermediate structures lie between medial and lateral structures, and median structures lie on the midline of the body. For example, the _____ (25) is a median structure. The frontal or coronal plane is a _____ (26) plane at 90 degrees to the median plane. It splits the body into _____ _____ (27) and _____ (28) halves. The terms anterior and posterior mean closer to the _____ (29) and closer to the _____ (30) of the human body respectively. For example, the _____ (31) is anterior to the upper back, the ears are posterior to the _____ (32). Transverse planes (also called horizontal or axial planes or cross-sections) are _____ (33) to both sagittal and coronal planes. They pass through the width of the body in a _____ (34) or transverse direction and divide the body into _____ (35) and _____ (36) sections. The terms superior and

inferior mean nearer the upper or lower end of the body respectively. For example, the nose is superior to the _____ (37) and inferior to the _____ (38). Cranial and caudal are often used interchangeably with superior and inferior. Superficial means _____ _____ (39) the skin surface, and deep means further away from the surface. For example, the _____ (40) is superficial to the heart. Proximal and distal mean _____ (41) or _____ _____ (42) from the root of the structure to be described. In the lower limb the shinbone is distal to the _____ (43) and proximal to the _____ (44).

Questions

Test yourself: Can you…

1. **…explain which anatomical parts form the human body?**
2. **…explain what is meant by the term "upper limb"?**
3. **…explain what is meant by the term "lower limb"?**
4. **…describe the anatomical position?**
5. **…describe the three different planes?**

2.3 The Parts of the Body

Additional info online

Exercise

Fill in the correct names for the different parts of the body in the illustration on page 34. Look up words you do not know in a medical dictionary or an English-language pictorial anatomy.

Note

Muscles are generally referred to by their Latin names, which are more or less identical with the ones used in the German language. You should, however, also be familiar with terms like pectoral muscles (pecs), hamstrings, quads, glutes, calf muscles, etc.

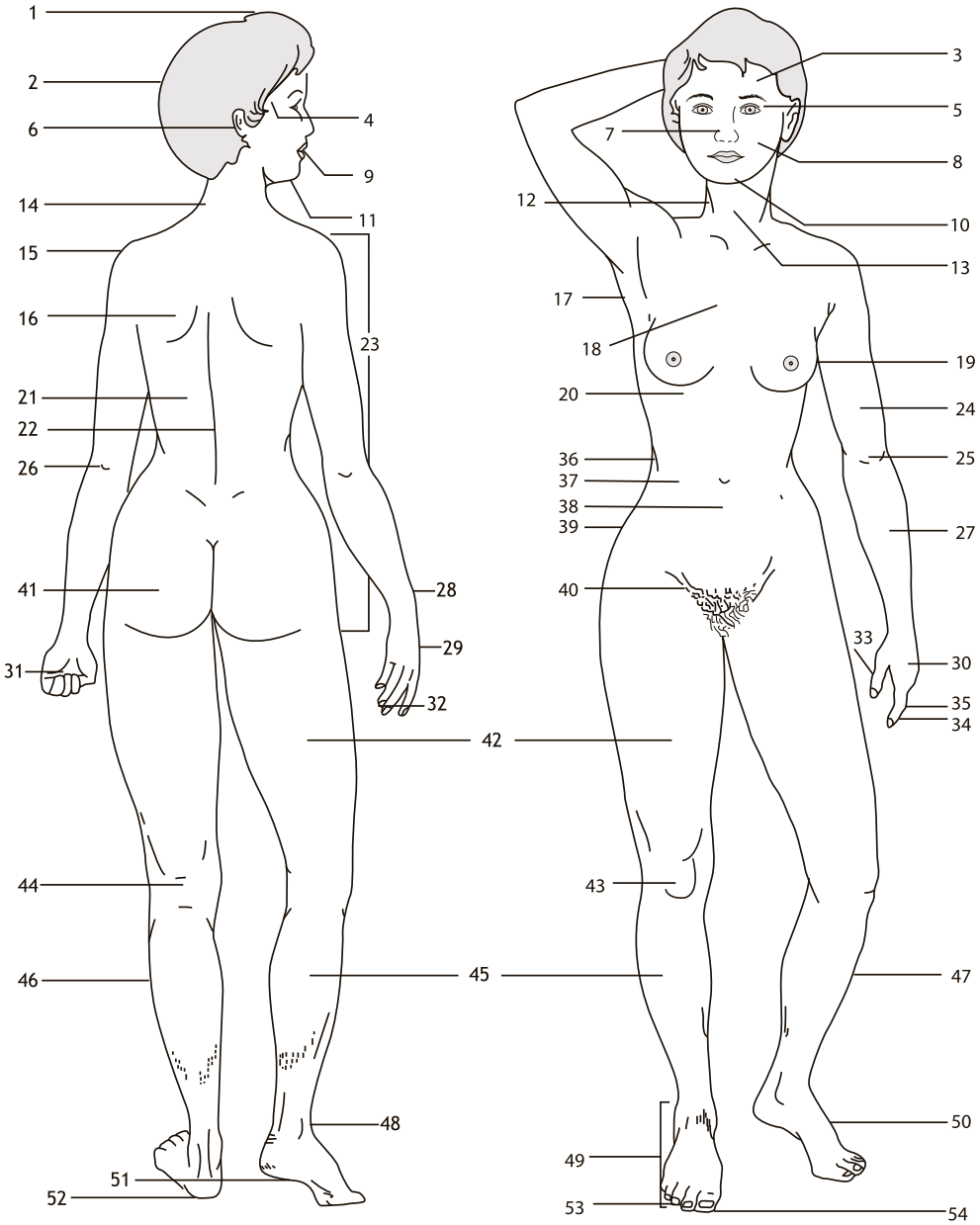
2.4 Compound Words in Anatomy

Exercise

Below is a list of some basic anatomical terms frequently used in combination with other words (1 to 17). First write down the German meanings of the words on the right. Then link each word with the appropriate group of words (A to Q) to form more specific anatomical terms. One example has already been done for you (the exercise is continued on page 31.).

1. arch = _____
2. artery = _____
3. bone = _____
4. bursa = _____

The Parts of the Body



5. cartilage = _____
6. cord = _____
7. gland = _____
8. joint = _____
9. ligament = _____
10. lobe = _____
11. muscle = _____
12. nerve = _____
13. node = _____
14. notch = _____
15. tendon = Sehne
16. vein = _____
17. vertebra = _____

	Achilles	
A)	trapezius	tendon
	supinator	
	elbow	
B)	hip	_____
	knee	
	carotid	
C)	maxillary	_____
	subclavian	
	palatal	
D)	plantar	_____
	vertebral	
	cardiac	
E)	deltoid	_____
	hamstring	
	cerebral	
F)	facial	_____
	laryngeal	
	clavicular	
G)	jugular	_____
	sternal	

2

	cranial	
H)	hyoid	_____
	thigh-	
	spinal	
I)	umbilical	_____
	vocal	
	lacrimal	
J)	pituitary	_____
	salivary	
	cranial	
K)	facial	_____
	optic	
	costal	
L)	cricoid	_____
	thyroid	
	ear	
M)	frontal	_____
	lung	
	cruciate	
N)	interspinal	_____
	cricothyroid	
	pharyngeal	
O)	popliteal	_____
	synovial	
	lymph	
P)	submandibular	_____
	vocal	
	cervical	
Q)	lumbar	_____
	thoracic	

2.5 The Brain and Nervous System

Additional info online

Exercise

The following list gives you various essential parts of the brain and the nervous system. Solve the anagrams by reading the clues and putting the letters in order to form words. The first one has already been done for you as an example.

1. phireprale veusron stemys = comprises cranial nerves, spinal nerves, nerve plexuses, and the spinal and autonomic ganglia associated with them: peripheral nervous system
2. oernun = functional cellular units of the nervous system responsible for communication among all body parts: _____
3. catlern surnove tesmys = consists of the brain and the spinal cord: _____ _____ _____
4. tromo rounne = carries impulses from the brain and spinal cord to muscles and glands: _____ _____
5. rosynes onerun = carries impulses from the sense organs to the brain and spinal cord: _____ _____
6. xona = a long fibre that carries impulses away from the cell body: _____
7. leymin hashet = lipid layer covering the axons of most neurons: _____ _____
8. stromutteraninne = a chemical substance that is used by one neuron to signal another: _____
9. ribna = the place to which impulses flow and from which impulses originate: _____
10. lapsin dorc = a rope of neural tissue that runs inside the hollows of the vertebrae from just above the pelvis and into the base of the skull: _____ _____
11. acistom souvern tysmes = division of the PNS that conducts signals from sensory receptors to the CNS and signals from the CNS to skeletal muscles: _____ _____ _____
12. flotran bole = associated with reasoning, planning, parts of speech, movement, emotions and problem-solving: _____ _____
13. icoplicat boel = associated with visual processing: _____ _____
14. troapelm lebo = associated with perception and recognition of auditory stimuli, memory, and speech: _____ _____

15. aripelat bleo = associated with the interpretation of sensory signals concerning movement, orientation, recognition and perception of stimuli: _____ _____
16. meclebrule = back part of the brain that is essential for refining movement, balance, equilibrium and posture: _____
17. nabri mest = controls the basic vital life functions such as blood pressure, breathing, heart beat, eye movement and swallowing: _____ _____
18. tipaurity dangl = responsible for secreting numerous hormones: _____ _____
19. tushalapohym = a small brain structure that controls body temperature, hunger and thirst, sexual behaviour, emotion and motivation: _____
20. maltaush = a large mass of grey matter serving as a gateway for incoming sensory information: _____
21. sugyr = a ridge on the surface grey matter of the brain: _____
22. lucsus = a groove in the surface grey matter of the brain: _____
23. crivanrutle stesym = contains and makes cerebral spinal fluid (CSF): _____ _____
24. labas gilgana = a system of subcortical structures that are important for the initiation of planned movement: _____ _____
25. brecreum = largest area of the brain associated with all higher mental functions, such as thinking and memory: _____
26. chapsipumpo = a brain structure important for converting short-term memory to more permanent memory: _____

2.6 Human Locomotion

Exercise: Which movements are being performed?

You are a physiotherapist assessing a patient's range of motion in different joints and asking him or her to perform various movements. Read the instructions below and fill in the professional term for the relevant movement performed as well as the relevant noun. The first one has already been done for you as an example.
Use the following list of words to find the right expression:

abduction	adduction	circumduction
depression	dorsiflexion	elevation
eversion	extension	external rotation
~~flexion~~	internal rotation *or* medial rotation	inversion
plantar flexion	pronation	supination

1. "Straighten your arm and lift it up towards the ceiling."
   The patient *flexes* his or her shoulder (*flexion*).

2. "Sit on the edge of the bed with your feet on the floor. Try to lift up the outside of your left foot."
   The patient _____ his or her ankle (_____).

3. "Keeping your elbow close to your trunk and bent at a right angle, move your forearm outwards to the side."
   The patient _____ his or her shoulder (_____).

4. "Stand up nice and tall. Now lean backwards as much as you can."
   The patient _____ his or her spine (_____).

5. "Sit on the edge of the bed. Try to touch your left shoulder blade with your left hand."
   The patient _____ his or her shoulder (_____).

6. "Sit in front of a table and place your forearm and the palm of your hand on the table."
   The patient's forearm is _____ (_____).

7. "Now turn your hand around so that the palm of your hand faces up."
   The patient's forearm is now _____ (_____).

8. "Sit on a chair keeping the soles of your feet on the floor. Lift up the toes and forefoot of your right foot as much as you can, but keep your right heel on the floor."
   The patient _____ his or her ankle (_____).

9. "Lift your shoulders up high as if you wanted to touch your earlobes."
   The patient _____ his or her shoulders (_____).

Note
Please remember that these instructions may also be useful for the exercises in ▶ Unit 4.

Note
The Appendix provides an overview of locomotion vocabulary.

10. "Now push them down, away from your earlobes."
    The patient _____ his or her shoulders (_____).
11. "Hold up your hand and try to rotate your thumb."
    The patient _____ his or her thumb (_____).
12. "Lie on your left side with hips and pelvis square. Now lift your right leg up towards the ceiling."
    The patient _____ his or her hip (_____).
13. "Sit on a chair with your feet on the floor. Press the soles of your feet together."
    The patient _____ his or her ankles (_____).
14. "Stand on your right leg only and push your right heel off the floor, so that you only stand on your toes."
    The patient _____ his or her ankle (_____).
15. "Your left arm is lifted up sideward. Slowly try to move your left arm down until it touches the left side of your trunk."
    The patient _____ his or her shoulder (_____).

2.7 The Physiology of Voice

Communication is necessary for most activities of daily life and can be expressed both nonverbally (e.g., via body language or facial expressions) and verbally (i.e., voice and speech). Although we do not normally think about our voice we are able to use it very well. Every voice is unique, like a genetic fingerprint. You can identify or recognize someone by their voice just as you can identify or recognize someone by the way they walk or by the way they look.

The normal voice includes three components: respiration, phonation (voice) and resonance. These components together with articulation produce speech. Let's have a closer look at each component:

Respiration
Respiration, or **breathing**, is a basic, involuntary and highly automatic function. It is controlled by the medulla oblongata, which is one of the oldest parts of the brain, located in the brain stem. Respiration can be divided into two parts: inspiration and expiration. As you will see muscles of both the chest and abdomen are i nvolved in the act of respiration.

Inspiration begins with the contraction of the diaphragm. The diaphragm is a muscle that separates the thoracic cavity from the abdominal cavity. Contraction of the diaphragm causes it to descend subsequently pushing the abdominal wall outwards. At the same time the rib cage wall expands. Together these mechanisms create a negative pressure within the lungs. This negative pressure forces air into the lungs causing them to inflate. Inspiration has now occurred.

After inspiration the diaphragm relaxes and ascends to resume its higher position. As the abdominal wall returns to its original position the rib cage collapses. These movements lead to deflation, whereby air is passively rushed out of the lungs. **Expiration** has now occurred.

This pattern of respiration, including inspiration and expiration, is called **"tidal" or "quiet" breathing**. It is the optimal way to breathe.

Phonation

Phonation is the process of **producing voice**. The organ primarily responsible for the production of voice is the larynx. It has two main functions. Firstly, the larynx serves to protect the lungs during the act of swallowing. It elevates while the vocal folds adduct to prevent food and fluids from entering into the trachea. You can feel the movement of the larynx by touching your throat with two fingers and swallowing. The second function of the larynx is the production of voice. In order to understand how the larynx is able to produce voice we have to take a closer look at the anatomy of the larynx.

The **larynx** is located on top of the trachea. It is made up of cartilages, muscles and ligaments. A well known cartilage is the **thyroid cartilage** and "Adam's apple". It is responsible for the amount of vocal fold tension. The **vocal folds** are located inside the larynx behind the thyroid cartilage and play the main role in the process of phonation. The vocal folds themselves are muscles covered by a mucous membrane. Depending on the supporting musculature and the position of the cartilages, the vocal folds are either opened, closed or tensed. This has an influence on the sound of our voice. When we breathe the vocal folds are abducted – opened. In this state air is able to pass in and out of the lungs. As long as we are just breathing, the vocal folds stay in this "open" position.

To produce a voice air must first be inspired. The vocal folds then move towards one another. Once together, the vocal folds remain adducted – closed. Movement and closure of the vocal folds are done by the active contraction of the **laryngeal muscles**. In order for the vocal folds to open again a certain amount of pressure below the closed vocal folds (also known as **subglottic air pressure**) is required. Once subglottic air pressure is sufficient, the expired air can push the vocal folds open. After air has passed through the open larynx, the vocal folds close again, this time via a mechanism known as the **Bernoulli effect**. The alternating movement of vocal fold opening and closing is a cycle of **vocal fold vibration**. The continuing process of vocal fold vibration creates **sound**, i.e. a tone.

The **pitch** of our voice depends on the tension of the vocal folds. When speaking in a high-pitched voice the vocal folds are long, thin and tensed. When you speak in a low-pitched voice the vocal folds are thick, short and relaxed. This is comparable to the strings of a guitar.

Resonance

How is it possible that a sound produced by such a tiny organ can be heard over a long distance? The answer is: resonance. Sound spreads out towards the **oral and nasal cavities** after passing through the larynx. Our voice becomes richer, louder and fuller in quality because of the resonating

properties of the oral cavity and nose. Playing the violin is a good analogy. The violin strings can be thought of as the vocal folds. The string's sounds are then amplified by the violin's body.

2

So far all we have produced is just a tone. For the purpose of speech this tone has to be modified by the **organs of articulation**: the tongue, teeth, cheeks, lips, lower jaw and soft palate. Here the tone can be transformed into individual sounds, for example, an /a/, /b/ or /k/. Which sound is produced is dependent on the place and manner of articulation and whether or not **voicing** occurs. For example, when the lips are closed the outgoing airstream can only pass via the nose and the sound of /m/ occurs. Blocking the outgoing airstream with the lips followed by a sudden opening of the lips, on the other hand, would instead produce the sound /b/ or /p/. Voicing then differentiates these two sounds, i.e. /b/ is voiced and /p/ is voiceless.

You know now that the "primary driving force of voice" is respiration. Due to contributing factors such as subglottic air pressure, expiration and the Bernoulli effect, the vocal folds inside the larynx are able to vibrate. Continuous vibration of the vocal folds produces a tone. This tone is strengthened by resonance and is modified by the articulation organs to produce speech.

Additional info online

Active Vocabulary: The Physiology of Voice

The English equivalents to these German words are used in the text. What are they?

- Artikulation, Lautbildung = _____
- Atmung = _____
- Ausatemstrom = _____
- Ausatmung = _____
- Bauchraum, -höhle = _____
- Brustraum, -höhle = _____
- Einatmung = _____
- hoch/tief (Stimmlage) = _____
- Klang = _____
- Konsonant = _____
- Körpersprache, Gestik = _____
- Luftröhre = _____
- Luftstrom = _____
- Mimik = _____
- Mundhöhle = _____
- Nasenhöhle = _____
- Phonation, Stimmgebung = _____
- Resonanz = _____
- Schildknorpel = _____
- schwingen, Schwingung = _____
- Stimmbänder = _____

- Stimmlippen = _____
- Tonlage = _____
- Vokal = _____
- Zwerchfell, Diaphragma = _____

Questions

1. **What are the different modes of communication?**
2. **How is a tone modified?**
3. **What does the Bernoulli effect contribute to?**
4. **How does inspiration occur?**
5. **Can you think of a situation in which the sound of someone's voice is particularly important?**

Discussion

Discuss the following statement:
"The voice is the mirror image of the soul!"

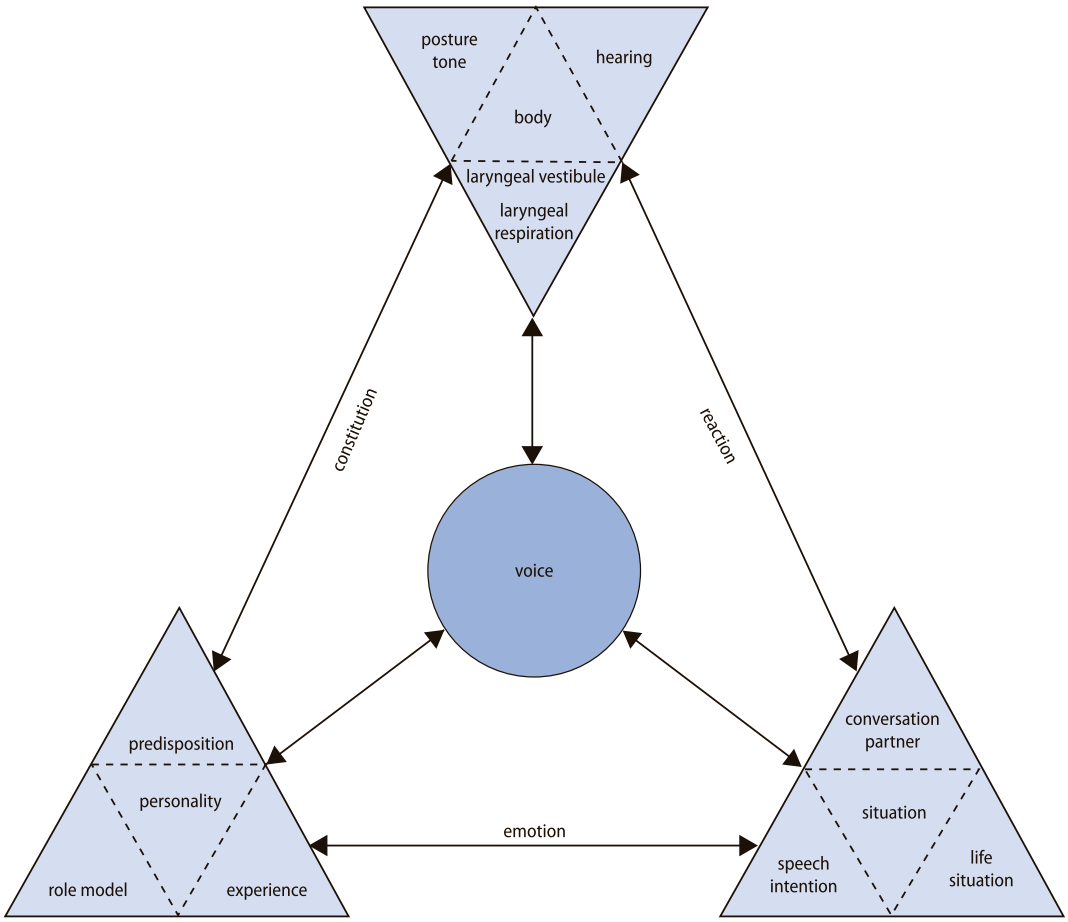
Exercise

Fill in the gaps by using appropriate words from the above text.

The _____ (1) is the part of the brain that controls breathing. Inspiration begins with the contraction of the _____ (2). _____ (3) of the lungs causes expiration. The main organ of phonation is the _____ (4). The _____ (5) or Adam's apple is responsible for the amount of tension of the vocal folds. The pitch of our voice depends on the _____ (6) of our vocal folds. The tongue, teeth, cheeks, etc. are _____ (7). A speech sound can be produced by _____ (8) the outgoing airstream with the lips. Resonance is achieved with the help of _____ (9).

2

Overview: Factors influencing voice



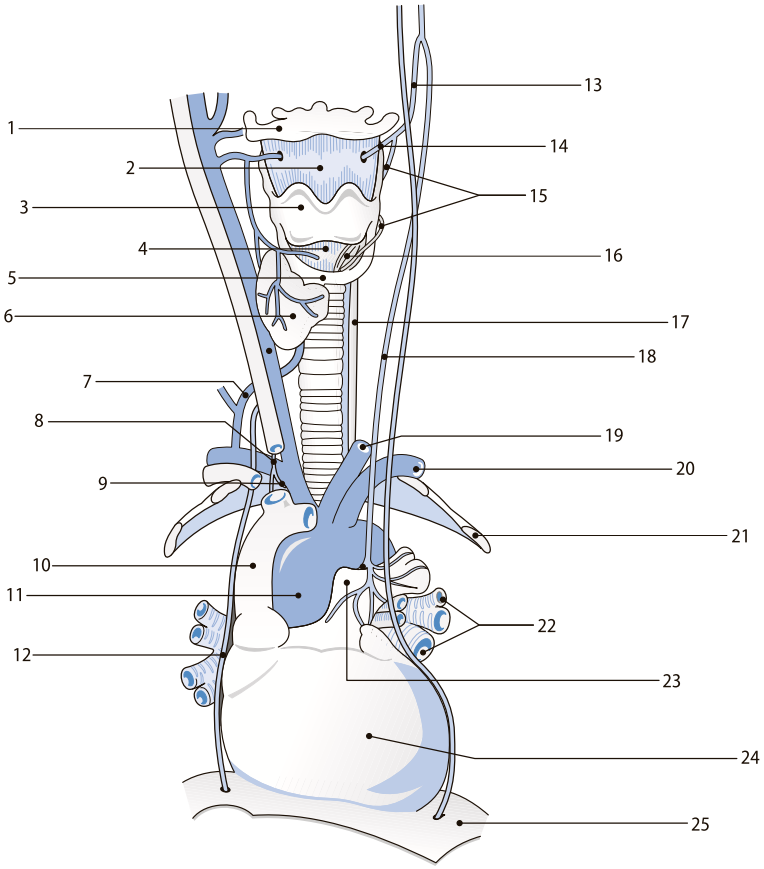
Discussion

1. **Do you agree with this model? Is it too difficult or too complex? Is anything missing?**
2. **Compare the above model with the information on voice production given in the text. Discuss whether they are compatible or whether one contains more or different information than the other.**
3. **Discuss the following statement:**

"The unique sound of the voice is influenced by personality, the physical body and context. A change in even one of these factors will directly impact the others."

2.8 The Larynx and Thoracic Cavity

Innervation of the Larynx



Exercise

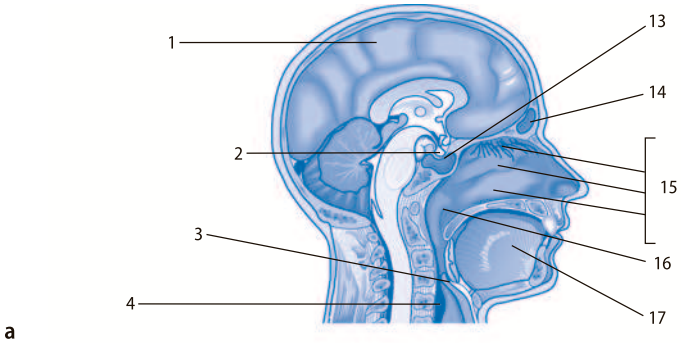
Match the anatomical terms in the table below with the appropriate numbers from the picture:

	aortic arch		bronchi (main/ primary bronchi)		common carotid *or* common carotid artery
	cricoid cartilage		cricothyroid membrane *or* cricothyroid ligament		cricothyroid muscle
	diaphragm		external branch of superior laryngeal nerve		heart
	hyoid bone		inferior thyroid artery		internal branch of superior laryngeal nerve

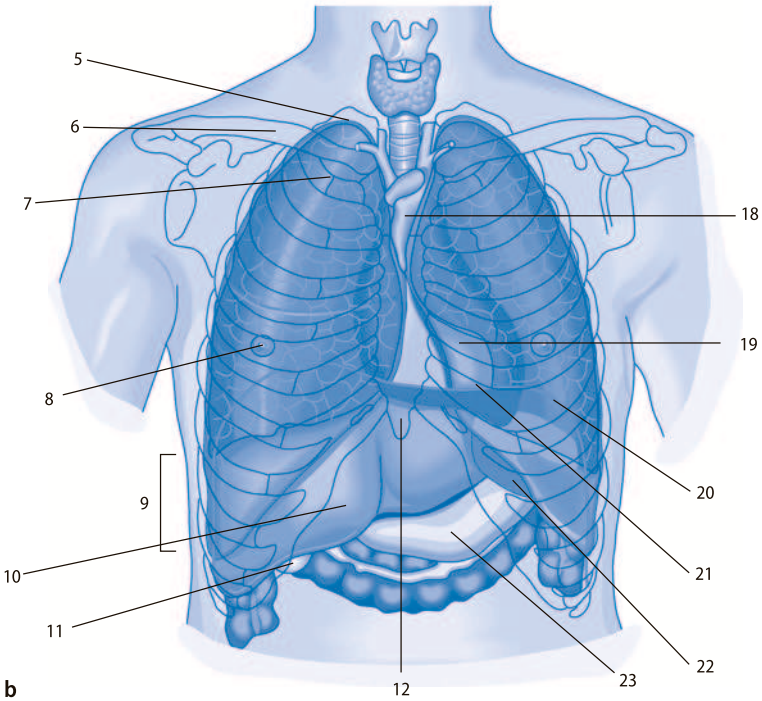
2

	(left) vagus nerve		oesophagus		phrenic nerve
	pulmonary artery		recurrent laryngeal nerve		rib
	(right) vagus nerve		subclavian artery		superior laryngeal nerve
	superior vena cava		thyrohyoid membrane		thyroid cartilage
	thyroid gland				

Thoracic Cavity



a



b

Exercise

Match the parts of the thoracic cavity from the table below with the appropriate numbers from the picture on page 46:

	aorta		apex of lung		cardiac notch		clavicle
	costomediastinal recess *or* costo-mediastinal sinus		dome of the diaphragm		epiglottis		eustachian tube
	falx cerebri		first rib		frontal sinus		gallbladder
	liver		nipple *or* mammary papilla		phrenicocostal recess/sinus *or* costodiaphragmatic recess/sinus		pituitary gland
	sphenoidal sinus		spleen		stomach		superior/middle/inferior nasal concha *or* superior middle/inferior turbinate bone
	tongue		windpipe *or* trachea		xiphoid process		

2.9 Auscultation of the Lungs

The auscultation of the chest describes **the process of listening to the sounds produced within the lungs and their analysis by using a stethoscope**. The auscultation of the chest is generally carried out in a quiet environment. The patient is requested to breathe in and out deeply with his or her mouth open.

The lung auscultation as well as a sound analysis of the nature of the determined chest sounds form the basis of the physiotherapeutic treatment plan and are repeated regularly.

They also form **part of the clinical reasoning process** according to which "evidence-based medicine involves integrating individual clinical expertise and the best external evidence available from systematic research" (Sackett et al. 1996).

One of the main roles of physiotherapists in the United Kingdom and the Republic of Ireland is the **management of manifold chest conditions**. It involves the detailed assessment of patients and the identification of their problems, the determination of short and long term goals and, finally, the provision of an effective physiotherapy treatment. In addition to the care of

chest patients **during regular working hours**, physiotherapists provide **weekend and on-call services** when required and are usually in charge of observing and managing chest patients **in the ICU** (Intensive Care Unit).

The basis of an efficient lung auscultation is a sound knowledge of the different lung surface markings, presented in detail in the following description.

Lung surface markings
Right lung
Lung apex: 2-3 cm above mid-clavicular line, passes along the centre of the sternum to the sixth costal cartilage.
To the 8th rib along the mid-axillary line.
To T10 posteriorly.
Oblique fissure: from T3 to 5th intercostal space in mid-axillary line to 6th costal cartilage anteriorly.
Horizontal fissure: from 5th intercostal space in mid-axillary line to 4th costal cartilage anteriorly.
Left lung
Lung apex: 2-3 cm above mid-clavicular line, passes along centre of sternum to 4th costal cartilage.
Passes approximately 3-5 cm laterally, then down to 6th costal cartilage anteriorly.
To 8th rib along the mid-axillary line.
To T10 posteriorly.
Oblique fissure: as right lung.
Pleurae
Coincide with the lungs, except inferiorly where they extend lower by approximately two ribs.

Auscultation findings
There are three main sounds to be heard during auscultation of the lungs: wheezes, crackles or creps and pleural rubs.

Wheezes are polyphonic sounds like many musical notes, mainly in expiration. They can also be monophonic at times. A polyphonic wheeze may represent a small narrowed airway, where the narrowing is caused by a combination of smooth muscle contraction, bronchospasm, inflammation within airways or increased bronchial secretions. A monophonic wheeze may be caused by a large airway obstruction such as one single narrowing caused by a tumour.

Crackles can be divided into four different types of creps: (1) non-musical (short uninterrupted sounds heard during inspiration), (2) early inspiratory crackles/creps, (3) late inspiratory crackles/creps and (4) expiratory crackles/creps. The first non-musical crackles represent equalization of intraluminal pressure as collapsed airways open during inspiration. Early inspiratory crackles are caused by a diffuse airflow limitation such as COPD or pulmonary oedema. Late inspiratory crackles are caused by conditions that largely involve alveoli, such as fibrosis or bronchiectasis. Expiratory crackles are caused by secretions.

The **pleural rub** is a leathery creaking sound associated with each breath. It sounds like "walking on snow". It is an inspiratory and expiratory sound,

which is not shifted by the cough and reoccurs at the same time in each respiratory cycle. The pleural rub can be caused by inflamed surfaces of pleurae rubbing together, like pneumonia, pulmonary embolism and emphysema.

Active Vocabulary: Ausculation of the Lungs

Additional info online

What are the English equivalents of the words listed below? They are all used in the above text.

- Atemzyklus = _____
- Bronchospasmus = _____
- Entzündung = _____
- Fibrose = _____
- Husten = _____
- Keuchen = _____
- Knistern, (Pleura-)Knacken; Krepitation = _____
- Lungenembolie = _____
- Lungenentzündung = _____
- Pleurareiben = _____
- Quietschen, Knarren, Knirschen = _____
- Sekret, Absonderung = _____
- Thoraxgeräusche = _____

Questions

Test yourself. Can you …

1. **… name the three main sounds on auscultation?**
2. **… name signs to be observed?**
3. **… name possible diagnoses for the three different sounds?**

2.10 Human Anatomy in English Proverbs and Sayings

Additional info online

Exercise

Here are some examples of anatomical terms used in everyday proverbs and sayings. Just one of the terms can be used correctly in each context. The first one has already been done for you as an example.

1. To be quite honest, I just cannot appreciate opera, ballet or abstract painting. My tastes are rather _____low brow_____; I like soaps and game shows on the telly.

   a) flat foot
   b) low brow
   c) thick skulled
   d) open mouthed
   e) soft brain

2. The CEO of the big health insurance company was very angry because, when he went to see the minister, he was left to _____ in an outer office for over half an hour.

   a) cool his heels
   b) rack his brains
   c) prick up his ears
   d) hold his tongue
   e) eat his heart out

3. Our receptionist was in a bad mood this morning. When I asked her if she'd had a good weekend she _____.

   a) trod on my toes
   b) got under my skin
   c) jumped down my throat
   d) gave me a pain in the neck
   e) stabbed me in the back

4. There are some people who flatly refuse to face any trouble. All they do is _____ and hope everything will be all right.

   a) put their hands on their shoulders
   b) keep their feet on the ground
   c) put their tongues in their cheeks
   d) bury their heads in the sand
   e) have their heads in the clouds

5. One of my patients always tells me how he met his future wife at the seaside during the holidays and how at the end of a week they were both _____ in love.

   a) hand over fist
   b) hand in glove
   c) eye to eye
   d) head over heels
   e) top to toe

6. Nobody likes having injections but they are necessary, and the best thing to do is to _____ and put up with them.

   a) bite your tongue
   b) grit your teeth
   c) tighten your lips
   d) hold your nose
   e) pull your hair

7. Wayne is not very good at ball games. Whenever he tries to catch a ball he seems to be all _____.

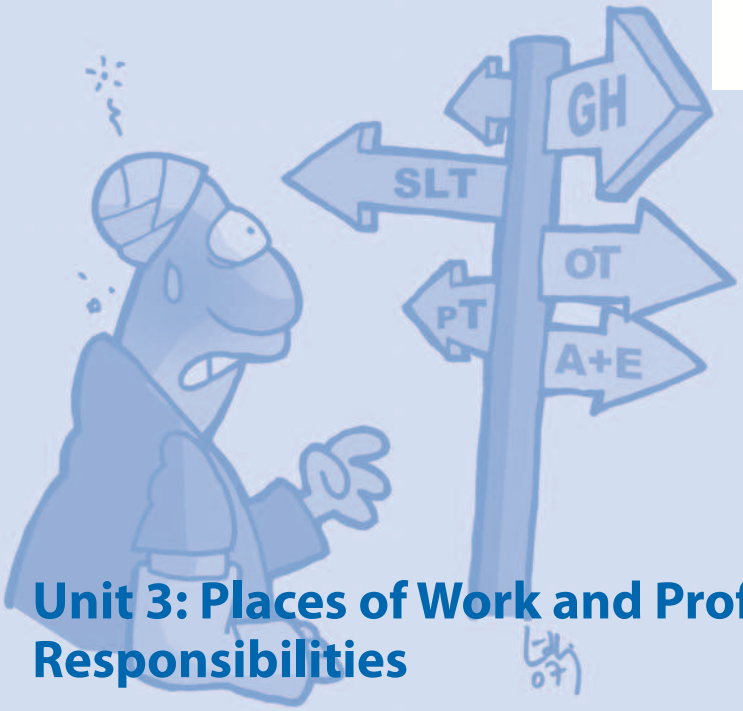
   a) feet
   b) fists
   c) knuckles
   d) thumbs
   e) joints

8. The students understood very little of the professor's lecture because most of what she said was completely _____.

   a) under their noses
   b) behind their backs
   c) over their heads
   d) over their shoulders
   e) above their eyes

9. "Wow, would you believe it? Francesca just told me that she did a Ph.D. in Communication Disorders at Georgetown University."
   "Actually, I think she's never even been to the States. She was only _____!"

   a) blinding your eye
   b) pulling your leg
   c) turning your head
   d) twisting your arm
   e) warming your heart



Unit 3: Places of Work and Professional Responsibilities

3.1 Allied Health Professions

The professions of **occupational therapy**, **physiotherapy** (as it is called in the United Kingdom and in Canada) or **physical therapy** (in the United States), and **speech and language therapy** (in the United Kingdom) or **speech-language pathology** (in the United States and in Canada) are all considered to be "allied health professions" (AHPs).

The term "allied health" is used to classify a large number of health care providers. It generally includes all the health-related disciplines with the exception of nursing, medicine, osteopathy, dentistry, veterinary medicine, optometry and pharmacy. Allied health professionals provide all kinds of **services**, including primary care, and they work in all types of settings, e.g. clinics, hospitals, laboratories, long-term care facilities, schools, community health agencies, etc. Their **responsibilities** include the identification, evaluation and treatment of diseases, injuries and disorders; health promotion; dietary and nutritional services; rehabilitation; and health system management. Allied health professionals have their own **caseloads of patients** and they are key members of a skilled, **multidisciplinary team**. This is in accordance with recent developments in the area of health care, where professionals with a range of different skills bring their particular **expertise** to caring for the patient.

Just like allied health professions are very diverse, so is their professional training. For some professions, there are **hospital-based educational programmes** and clinical training, others require **university-based programmes** where students graduate with a bachelor's or master's degree (e.g., occupational therapy, physiotherapy and speech and language therapy). In some professions there is **supportive personnel**, i.e. aides and technicians who assist therapists – e.g. occupational therapy assistants (OTAs), physiotherapy assistants (PTAs) and speech and language therapy assistants (SLTAs).

Exercise

Here are some disciplines commonly recognized as allied health professions. Find out the professions that are described by getting the syllables into the right order . Write your answers horizontally in the grid. If a term consists of several words, leave gaps between them. The first one has already been done for you as an example.

1. ther a art py = concerned with the creative process of art making as a means to improve and enhance the physical, mental and emotional well-being of individuals of all ages

2. gy di au o ol = concerned with testing and diagnosing hearing and balance disorders, with aural rehabilitation, hearing aids and other amplification devices

3. cal i med nol o tech gy = concerned with identifying data on the blood, tissues and fluids of the human body (in the USA known as clinical laboratory science).

4. pi to res ra ry py ther a = concerned with the respiratory care of patients in trauma resuscitation, emergency and critical care, and pulmonary and cardiac rehabilitation

5. e di ics tet = concerned with applying principles derived from nutrition, biochemistry, physiology and food management to improve an individual's health status

6. med ics para = concerned with the emergency care of sick or injured people during transport to hospital

7. thop or tics = concerned with investigating, diagnosing and treating visual defects and abnormalities of eye movement

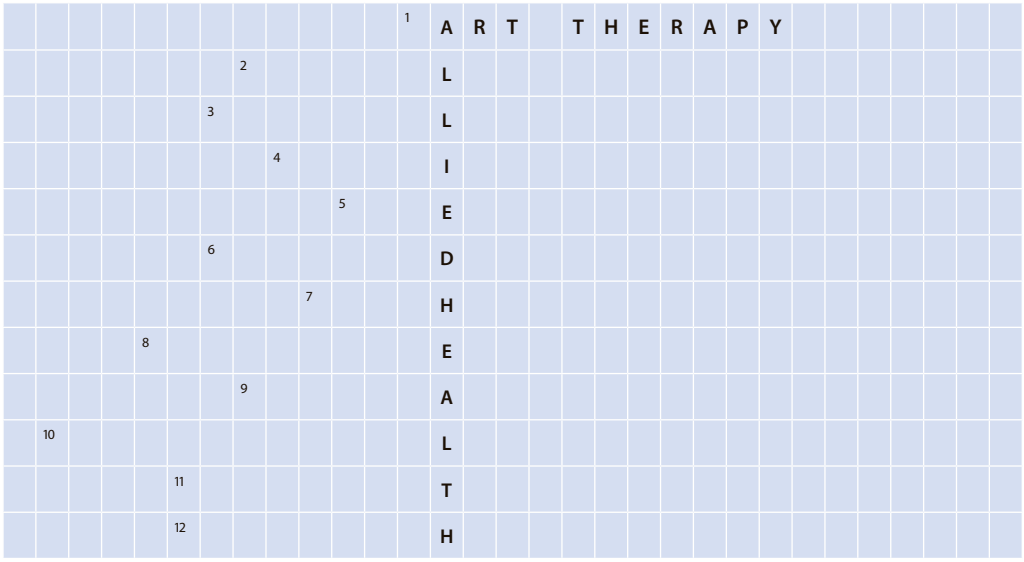
8. a py io ther phys = concerned with diagnosing and managing movement dysfunction and enhancing physical and functional abilities

9. pa ther oc a cu al tion py = concerned with helping individuals perform life tasks through the use of purposeful activity

10. py guage a and ther lan speech = concerned with diagnosing and remediating communication difficulties

11. and thot pros ics thet ics or = concerned with providing care for individuals requiring an artificial limb (prosthesis) or a device to support or control part of the body (orthosis)

12. ther sic py mu a = concerned with using both instrumental and vocal music strategies to address the physical, emotional, cognitive and social needs of individuals of all ages



3.2 What Do Occupational Therapists, Physiotherapists and Speech and Language Therapists Do?

3 **Additional info online**

Aaron is a transitioning student in his last year of Sixth Form College. At present he is completing a week of job experience to gain insight into PT, OT and SLT at a general hospital in London. Today is his third day of job experience visiting the three different AHP departments. In the tea break he discusses professional duties with Simon (an occupational therapist), Rebecca (a physiotherapist) and Theresa (a speech and language therapist).

Theresa: So Aaron, what do you think of your stay here so far?

Aaron: I have been with each one of you since Monday and I must say it is all really very interesting.

Simon: So what do you want to study once you've finished your A levels?

Aaron: I'm not sure yet. I certainly want a job where I can earn some money…

Theresa (jokingly)**:** Wow, what a typical male answer!

Aaron: Sounds pretty bad, I know, but if you think of it, I'd like to have a good life when I've finished studying.

Theresa: I know what you mean. After three or four years of study we all start off with the same salary scales within all of the allied health professions. I think at present the junior starting salary scale is £18,000 to £20,000… and Senior II I believe is £20,000 to £24,000. It's alright really. Unless you want to stay on and do your master's. You'll have completely different options then.

Aaron: I think I'd prefer to finish with a normal bachelor's. I need to work first before I decide on a master's course.

Rebecca: Good choice, but do you know that compared to the other two professions, you will have to work weekends as a physio? You'll have to do weekends until you are in a Senior I position. You can earn quite a bit more money this way!

Simon: Yeah, come on Rebecca, it isn't all about money though, is it? Aaron, as an occupational therapist you are really involved in your patient's life and progress. It is really interesting and hands-on. It is never boring and quite diverse. As an OT working in a hospital for example, you could be assisting inpatients with their ADLs in the morning on the wards and then do a home visit in the afternoon. It's great fun! On a home visit you would go and assess a patient's home and see what changes need to be made before he or she can return home safely. There is usually a family member with you and you get tea and biscuits…

You would also organize wheelchairs or devices such as sliding boards or shower chairs, even hoists for the home if necessary. You could also work in GP practices, schools, nursing homes and even in prisons, depending on which area of OT you decide to go for.

Aaron: Why, how many more areas are there?

Simon: Oh, loads…there is physical rehab, paediatrics, learning disability, equipment for daily living, but also mental health and even research posts. Generally, you will have to carry out different assessments on mental health status and cognitive abilities as well as mobility status. The occupational therapist is a very important rehab team member, as we supply our clients with whatever they need in order for them to return home with as high a level of independence as possible. Really, we are very much involved in deciding whether a patient is able to return home or needs to stay in a nursing home. The doctors usually ask us for our opinion.

Theresa: Yes, but an SLT has just as much responsibility as the OT as far as assisting clients to regain a high level of independence goes. Or do you think a patient could return to live independently if he or she was not able to communicate, read and express his or her needs, thoughts and feelings? See, Aaron, as an SLT you would not only work with patients suffering from language or communication problems, but also with people who have eating or swallowing problems. You would be responsible for carrying out and assessing videofluoroscopies, listen to people's chests and throats with a stethoscope for residual fluids or foods and by doing so evaluate, for example, whether he or she is aspirating. You would also be responsible for the care of patients with tracheostomies and educate them on how to look after their traches themselves.

Rebecca: The physios often work closely with the SLTs, especially regarding chest patients. We would assist the SLT by having another close listen to a patient's chest if he or she is query aspiration. Just a few days ago we had an in-service in the hospital concerning tracheostomies. Theresa was presenting the SLT side of it and our respiratory senior physio explained the physio aspects of traches.

Theresa: Speech and language therapy is also quite diverse. You could be working in hospitals, community health centres, mainstream and special schools, day centres and clients' homes. We treat people who suffer from strokes, mouth and throat cancer, head injuries, hearing loss and deafness, physical and learning disabilities as well as psychiatric disorders. We always work in teams for instance with other AHPs, doctors, nurses or even teachers. It is never boring and you are never alone…

Rebecca: We also work closely with other AHPs. I often do joint assessments with Simon, for example, when we need to assess a client's mobility status. We assess the elderly mobility scale or other standardized assessments together and then evaluate the results individually and profession-specific afterwards. It is very interesting. I also often refer my patients on to OT or SLT if required.

Simon: So you see, this is another good thing about any of the three professions. You are an independent practitioner with responsibility to assess your patient caseload and, if required, refer them back to their GPs or consultants or any of the other health care professionals.

Rebecca: We still rely on the initial GP or doctor referral though – at least in the public sector. In order to treat patients in the hospital you need a referral card stating a medical diagnosis. From then on the AHP will assess his or her patients and establish a therapeutic "diagnosis", which is different to the actual medical diagnosis. This is an analysis of the therapeutic objective findings, if you understand what I mean. The AHPs decide independently from the doctor, but with the patient's consent, when he or she is to be discharged from therapy.

Aaron: So where would you work as a physio then?

Rebecca: Oh, there are many possibilities. Just like the other two professions, physios work in hospitals, ICU or HDU, palliative care and women's health, community care, day care centres, GP practices and, of course, the private sector. There again you are completely on your own. Patients often consult you without having seen a doctor. It requires a high level of expertise and responsibility as it is up to the private practitioner to gather all information necessary to fully assess the patient's condition. In private practice you very often have to send your clients to their GP or to get x-rays done before you can act and treat their conditions.

By the way, I forgot to mention the option of working in sports physiotherapy, which is very interesting. You could even look after a rugby or football club!

Aaron: Now you told me how you work together with the other two professions, but what exactly do you do then?

Rebecca: Well, I currently work in neuro rehab. I look after various neurological conditions, mainly strokes and head injuries. I look after them on the rehab ward as well as in ICU. I assess the patients and meet their families in order to develop treatment goals and also to keep the families informed of the progress we make. In neuro rehab my aim really is to assist my patients in regaining the most achievable and realistic level of independent mobility for them. For those who will not regain any active mobility, I aim to maintain their current ROM and muscle strength and prevent deterioration. I am very often involved in the decision-making process of whether a person is safe and able to return home or whether he or she might benefit from a period of convalescence or even whether he or she should move to a nursing home for good. This is just one aspect of my job description at present.

Aaron: To be honest, it all sounds really interesting and exciting to me. It will certainly be a difficult decision for me to make. At least one thing is for sure, I will not do medicine. Doctors really work non-stop, don't they? I like the AHPs as they only work 37 hours a week in the UK and a 33-hour week in the Republic of Ireland.

As to which of the three professions I'll choose, I'm glad I still have a few months to think about it…

Questions

1. What are the responsibilities of OTs, PTs and SLTs in the United Kingdom?
2. In which settings do they work?
3. What is their education like?

Please discuss these questions in comparison with what you know about the situation of therapists in Germany.

4. Have a look at the table of AHP grades and possible specializations in the Appendix. Which AHP grade applies to you?

Exercise

Write a brief statement (no more than 500 words) on why you decided to become an occupational therapist, physiotherapist or speech and language therapist and what you like (or dislike) about your work.

Discussion

1. Imagine you had to describe the "ideal" OT, PT or SLT. Can you agree on any typical characteristics of such a person? If yes, what are they?
2. In your opinion, do the general public have any stereotypical image of OTs, PTs, SLTs or their professions? If yes, does that have any influence on your professional self-image?

Simulation Task

Imagine you've gone to the pub for after-work drinks with some colleagues. One of you is new at work and just starting to get to know all the others. Get together with a small group of people. Practise introducing yourself and your workplace and asking questions about other people.

"Hi there, I'm Karen. I don't think I have seen you around before."

"No, that's true, I'm new at Bronglais Hospital. My name is Will and I'm a physio in the outpatient department."

etc.

Active Vocabulary: Workplace Structure

… to be headed by …	… unter Führung von … / … geführt von …
… to report to …	… unterstellt sein …
… to be accountable to …	… gegenüber verantwortlich / rechenschaftspflichtig sein …
… to be supported by …	… unterstützt werden von …
… to be assisted by …	… unterstützt werden von …
… to be responsible for …	… verantwortlich sein für …
… to take care of …	… erledigen … / … betreuen …
… to be in charge of …	… leiten … / … beaufsichtigen …

3.3 The Working Conditions of Occupational Therapists, Physiotherapists and Speech and Language Therapists around the World

Have you ever wondered what the job situation is like for allied health professionals in South Africa, how much a physiotherapist earns in Canada, in

which settings speech and language therapists work in Australia, how to get registered as an occupational therapist in New Zealand, etc.? In our globalized age it is possible to gather a lot of information quite easily from the internet.

Exercise

Look up information and write a short essay (approx. 700 words) on the work situation of one particular allied health profession in the English-speaking country of your choice. Alternatively prepare a PowerPoint presentation on this topic (ca. 10 minutes) for your fellow students.

A useful starting point for your research could be the websites of professional associations (e.g., the Australian Association of Occupational Therapists), registration boards (e.g., the Physiotherapy Board of New Zealand), health ministries (e.g., the Irish eGovernment website) or national health care providers (e.g., Medicare Australia).

Note

Don't forget that the World Federation of Occupational Therapists (WFOT), the World Confederation for Physical Therapy (WCPT) and the International Association of Logopedics and Phoniatrics (IALP) give you access to information on their member countries via their websites.

3.4 Occupation – Movement – Communication

Exercise/Discussion

1. **Every profession has its own domain, its own core subject area. What is the central point of self-reference for occupational therapy, physiotherapy or speech and language therapy in your opinion?**
   Please take some notes and then discuss your ideas with members of the other professions.
2. **How would you define movement, occupation and communication?**
   Please take some notes and then discuss your definition with someone from your own or another profession.
   Now have a look at the following definitions from authoritative professional sources and compare them with your own ideas.

Communication

Communication is the reciprocal act of exchanging information and ideas. It is an active process including the encoding, transmitting and decoding of messages (Shames et al., 1994). Speech and language are but one component of this process. A set of rules govern speech and language to ensure that the formation of words and grammar is correct and that the intended meaning is sent and received. **Paralinguistic**, non-linguistic and metalinguistic components make up the rest of the communicative act. Paralinguistic mechanisms serve to signal attitude or emotion and include intonation, stress, rate of message delivery, pause or hesitation. **Non-linguistic** behaviours include gestures, body posture, facial expression, eye contact, head and body movement and proxemics (physical distance) and also serve to influence or enhance communication. **Metalinguistic** skills are

those which allow us to talk about language and analyse how it is being used. Metalinguistic skills enable one communication partner to monitor what and how the other communicates. Communication always occurs within a context (= communicative context) and is influenced by preceding and current events and shared social knowledge between communication partners (Shames et al., 1994).

Movement

Movement "involves a change of position of the body and its components. This extends to change in location of the whole body from one physical space to another. The act of movement allows humans to sustain life; to explore their physical and social environment; and to seek out their basic needs, housing, companionship, knowledge and self-actualization. Movement occurs on a **continuum** from the microscopic level to the level of the individual in society. […] Movement levels on the continuum are influenced by physical, psychological, social and environmental factors. Movement does not occur in isolation. The control of an individual's movement is dependent on internal and external factors that have important qualitative and quantitative influences on that movement." (Cott et al., 1995, p. 88)

Occupation

Occupation ist defined by the Occupational Therapy Practice Framework: Domain and Process (Youngstrom et al., 2002) as "…everything people do to occupy themselves, including looking after themselves…enjoying life…and contributing to the social and economic fabric of their communities…" (p. 610). Activities of daily living (ADL), (e.g. bathing, dressing, eating), instrumental activities of daily living (IADL), (e.g. care of others, child rearing, cooking, shopping), education, work, play, leisure and social participation are the main areas of activity in which people engage. These activities are called occupations. The main objective and focus of occupational therapy intervention is "**engagement in occupation to support participation in context**" (p. 611). Health and wellness can be supported and maintained when individuals are able to engage in occupations that allow participation in home, school, workplace and community-life situations.

3.5 Occupational Therapy Models of Practice

A major contribution of the occupational therapy profession to the concept of health is its over-all conviction that engagement in occupation supports participation in life. More specifically, health is supported and maintained when individuals are able to engage in activities of daily living that allow participation in the various life situations at home, at school, at work, at play and in the community.

The concept of restoring, maintaining and enhancing function through purposeful activities has evolved throughout the profession's history to become known in modern terms as **occupational performance in context**. Along with conceptual development come changes in terminology that express the evolution of the professional language. The term "function"

turns into **occupational performance**, for instance, and the "patient" becomes a **client**. Occupational therapists provide services not only to individual clients with disabilities and chronic conditions, but also preventive services to individuals who are at risk of disablement. Furthermore, occupational therapy services have moved beyond individual treatment to include the family, caregivers, teachers, employers and organizations or groups in the community. This means that the client is seen within his or her environment or **context(s)**. The term "purposeful activities" is defined as **occupations** (daily life activities that are purposeful, meaningful and important to the client) and **engagement** implies that the performance of occupations is not only seen as physical actions, but includes the psychological and emotional components of being human.

Not only has the professional language evolved over the years, but models of practice have developed that have a new focus on person-environment-occupation (PEO). Although these models have their origin in occupational science, they are gaining acceptance in clinical practice and have similarities to approaches provided in community health services. PEO models focus on health promotion and disease prevention, as well as institution-based services and thus support occupational therapy practitioners in developing effective **client-centred interventions**. Client-centred practice means that occupational therapists work in partnership with their clients, creating a caring and empowering environment in which clients direct the course of their care. The clients are involved in formulating their own goals and with the guidance of their occupational therapist, discover, or re-discover their own inner resources. Examples of such PEO models of practice in occupational therapy are: The Model of Human Occupation (MOHO), the Canadian Model of Occupational Performance (CMOP), or the Occupational Performance Process Model (OPPM), among others.

The occupational therapy intervention process integrates observations and evaluations with theory, frames of reference, clinical reasoning, and evidence to develop a plan for intervention. As the PEO models of practice maintain, intervention implementation is a collaborative process between the client and the occupational therapist. The focus of intervention may vary according to context, activity demands, client factors (such as body functions and body structures), performance skills (motor skills, process skills or interaction skills), or performance patterns (habits, routines and roles). All models of occupational therapy practice include the therapeutic use of self and the therapeutic use of occupations and activities. Occupational therapists provide consultation and education in collaboration with their clients in context, using their knowledge and expertise to assist the client in achieving their own goals of occupational performance, role competence, adaptation, health and wellness, and a desired quality of life.[1]

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1 For further reference see: Youngstrom MJ (2002) Occupational therapy practice framework: domain and process. Am J Occupational Therapy 56: 609–639; Law M, Baum CM, Baptiste S (2002) Occupation-based practice: fostering performance and participation. SLACK Incorporated, Thorofare, NJ

Active Vocabulary: OT Models of Practice

What are the English equivalents of the words listed below? They are all used in the above text.

- Adaption, Anpassung = _____
- Aktivitäten des täglichen Lebens = _____
- auf/bei der Arbeit = _____
- beim Spiel = _____
- Beobachtung = _____
- Betätigung, Handlung, Tätigkeit, Beschäftigung = _____
- Beteiligung, Beschäftigung = _____
- Bezugsrahmen, Bezugssystem = _____
- erhalten, aufrechterhalten = _____
- Evaluation, Bewertung, Beurteilung = _____
- Evidenz, Nachweis, Beweis = _____
- Fachsprache, Fachwortschatz, Terminologie = _____
- Fachwissen = _____
- fördern, steigern, erhöhen = _____
- Gemeinde, Gemeinschaft = _____
- Gewohnheit = _____
- Handlungskompetenz, Betätigungsausführung, -durchführung = _____
- in der Schule = _____
- Interaktionsfertigkeiten = _____
- klientenzentriert = _____
- Kontext = _____
- Lebensqualität = _____
- Leistungs-, Performanzfertigkeiten = _____
- motorische Fertigkeiten = _____
- Praxismodell = _____
- Rolle = _____
- Routine = _____
- Teilhabe, Beteiligung = _____
- Umwelt, Umgebung, Umfeld = _____
- Verarbeitungsfertigkeiten = _____
- wiederherstellen = _____
- Wissen = _____
- zu Hause = _____
- zweck-/zielgerichtete Aktivität = _____

Additional info online

Questions/Discussion

1. **Which of the models mentioned in the text did you learn about during your professional training? Which other OT models do you know? Which models of practice are used in physiotherapy or speech and language therapy? Briefly explain other models to your fellow students so that you can try to make comparisons.**
2. **Discuss your own experience with models of practice with your fellow students: Which models have you already used in your practical work? What did you find helpful and what did you find challenging about using such models in practice?**
3. **In which way can a heavy reliance on models limit the advancement of allied health professions as academic disciplines?**

3.6 Therapeutic Treatment Methods in Occupational Therapy and Speech and Language Therapy

Additional info online

Types of occupational therapy interventions

The following types of occupational therapy interventions are listed in Youngstrom et al. (2002). Fill in possible treatment methods from the table below that seem appropriate to the examples given. The first one has already been done for you.

ADL training	arts and crafts	~~establishing a therapeutic relationship~~
fine motor training	mobility training	neuromuscular facilitation
perceptual and cognitive training	sensory integration therapy	social competence training
splinting techniques		

Therapeutic use of self: A practitioner's use of his or her personality, insights, perceptions, and judgements as part of the therapeutic process.

Method: establishing a therapeutic relationship (1)

Therapeutic use of occupations and activities: Occupations and activities are selected for clients that meet their own specific goals.

Examples of **occupation-based activities:**

- putting on clothes without assistance
  purchasing one's own groceries and preparing a meal
  Method: _____ (2)
- painting a picture
  Method: _____ (3)

Examples of **purposeful activities:**

- practising drawing a straight line
  Method: _____ (4)
- role-playing to learn ways to manage anger
  Method: _____ (5)

- practising safe ways to transfer from wheelchair to toilet
  Method: _____ (6)
- organizing space and tools for a woodworking project
  Method: _____ (7)

Examples of **preparatory methods:**

- promoting adaptive response through sensory input
  Method: _____ (8)
- designing and fabricating a wrist support
  Method: _____ (9)
- reducing spasticity
  Method: _____ (10)

Types of speech and language therapy interventions

Additional info online

aphasia therapy	articulation training	augmentative and alternative communication (AAC)
aural rehabilitation	cognitive-communication therapy	fluency training
oral-motor exercises	relaxation	respiration training (for speech)
resonance management	supportive communication	vocal hygiene

Examples of **activities for voice/resonance/fluency disorders**:

- reducing excessive muscular tension in a targeted muscle group
  Method: _____ (11)
- fitting a prosthetic device to reduce hypernasality
  Method: _____ (12)
- teaching gentle onset of phonation
  Method: _____ (13)
- eliminating vocal misuse and vocally abusive behaviours
  Method: _____ (14)

Examples of **activities for adult neurogenic language disorders**:

- teaching client and spouse/partner how to use pen and paper for drawing and writing while conversing
  Method: _____ (15)
- asking client to point to pictures of household items
  Method: _____ (16)
- creating a memory book with names of family members, therapists, personal data, appointments
  Method: _____ (17)

Examples of **activities for speech disorders**:

- repeating speech sounds and words
  Method: _____ (18)
- teaching controlled and sustained exhalation
  Method: _____ (19)
- doing exercises to increase range, strength and movement of facial musculature
  Method: _____ (20)

Note
The vocabulary from this chapter may also be useful for some of the exercises in ▶ Unit 4.

Examples of **activities for non-verbal communication**:

- teaching American Sign Language (ASL) to complement some oral speech
  Method: _____ (21)
- prescribing a voice output communication aid
  Method: _____ (22)

Additional info online

3.7 Physiotherapy Fields of Activity and Clinical Practice

The following table shows a variety of fields of activity and clinical practice in which physiotherapists work and specialize. Read the different statements below given by physiotherapists and find out which discipline they are talking about. Write the relevant discipline next to each statement. The first one has already been done for you as an example.

cardio rehabilitation	intensive care	musculoskeletal
~~neurology~~	oncology and palliative care	orthopaedics
paediatrics	respiratory care	rheumatology
sports medicine	traumatology	vascular surgery and rehabilitation of amputees
women's/men's health		

1. "I assess and treat manifold complex conditions. My treatment goal is to promote and facilitate normal movement. I apply whichever technique allows my patients to move in a more physiological way and offers them new means and skills to regain their independence. In order to carry out my treatments efficiently I often rely on multidisciplinary teamwork and the help of physiotherapy assistants."

Field of Activity/Clinical Practice: neurology

2. "I rely on the use of objective measures and devices to monitor the progress of my patients closely as possible mistakes could be fatal, and very often my patients are sedated and unable to express themselves. My work further involves intensive communication with the medical team and nurses in charge."

Field of Activity/Clinical Practice: _____

3. "In my job empathy and an understanding for the patient's emotions and worries is sometimes more important than the actual physiotherapy intervention. Listening and communication skills are essential to dealing with communication challenges within the clinical field I work in."

Field of Activity/Clinical Practice: _____

4. "I like the general fitness of my patients. They are usually very keen to improve and very compliant with their treatment. I can choose from a wide range of different treatment tools, such as cryo- or electrotherapy devices or taping techniques as well as the use of a treadmill, for example. In some cases I can even carry out cardiopulmonary endurance tests."

Field of Activity/Clinical Practice: _____

5. "I rely on the use of assessment tools, which allow me to analyse my patients' conditions adequately. I use tools for auscultation, interpret blood gases, evaluate X-rays and monitor my patients' O_2 saturation and heart rate during mobilisation."

Field of Activity/Clinical Practice: _____

6. "In order to treat my patients safely I often have to follow strict protocols, which determine exactly what activities my patients are allowed to perform, how often and when. I must asses their vitals on a regular basis to make sure there are doing fine and that they are still within a normal exercise range."

Field of Activity/Clinical Practice: _____

7. "One particular group of my patients has strict orders on how to get in and out of bed. Many conditions in the discipline I work in are subject to following strict protocols."

Field of Activity/Clinical Practice: _____

8. "Pain and frustration are probably the two factors which affect my physiotherapy treatment the most. A lot of my patients tend to have a long history of pain. Some of my patients find it easy to deal with their conditions, others need to learn to accept their 'new selves' as their conditions often have a major impact on their life; some even call it a 'new life.'"

Field of Activity/Clinical Practice: _____

9. "The patients I treat generally find it very difficult to talk about their problems. They usually attend physiotherapy as a last resort. They often are embarrassed by their conditions, but they are usually very grateful for help and very compliant with the therapy process. It is a rather new clinical field for the physiotherapy profession."

Field of Activity/Clinical Practice: _____

10. "I enjoy the diversity of the conditions that I treat. I need to have a sound understanding of human anatomy and muscle physiology of all the joints as well as the spine in order to be able to treat the variety of patients that attend for physiotherapy. In my clinical field of activity the attendance of manual therapy courses is recommended."

Field of Activity/Clinical Practice: _____

Note

The vocabulary from this chapter may also be useful for some of the exercises in ▶ Unit 4.

11. "The patients that I treat suffer from chronic conditions. I have attended several courses in splinting and hand therapy. Pain and stiffness are major factors that affect the life of my patients. I often use the hydro pool or heat or cryotherapy methods to treat my patients."

Field of Activity/Clinical Practice: _____

12. "In order to treat my patients I rely on the compliance of their parents. I aim to involve them actively in my treatment sessions and advise them on how to carry out certain actions at home."

Field of Activity/Clinical Practice: _____

13. "I treat trauma patients who sustained fractures following RTAs, for example. Some of my patients had surgery following their injury; others don't qualify for surgery for various reasons (e.g., age, co-morbidities) and are therefore treated conservatively."

Field of Activity/Clinical Practice: _____

3.8 Working in Private Practice in the USA

For some occupational therapists, going into private practice is often a move towards the **achievement of a dream**, a desire to do something on their own after having acquired years of experience in hospital settings, rehab centres, mental health outpatient clinics or school settings. When it comes to starting their own business, occupational therapy practitioners in the U.S. often begin their services as a part-time adventure while still working full-time. A transition to self-employment requires a love for the profession, lots of **energy, patience, management skills and creative ideas**.

The first issue to be dealt with is insurance reimbursement. Whether an OT works part- or full-time, insurance companies and Medicare require registration as a contracted provider of services and they require an appropriate environment for provision of care. A private practice must have wheelchair accessibility, proper safety measures (e.g., fire extinguishers, fire exits), hygienic bathrooms, adequate lighting, heat, air, and ventilation, and proximity of free parking.

Through word-of-mouth and letters of introduction to doctors (who prescribe occupational therapy services), outpatient clinics or school districts, etc., additional **contract opportunities** can be found. Often

occupational therapists join up with other professionals (e.g., physiotherapists, speech and language therapists, dieticians) to provide comprehensive therapy services.

Usually private practice settings are specialized, for instance paediatric practices are very common. In a full-time practice, 10-12 clients with a variety of diagnoses are typically treated each day. Private practice requires excellent time management and flexible thinking in order to provide quality services to clients and their families and to provide appropriate documentation of intervention.

Reimbursement through Medicare and most insurance companies only covers services delivered directly to the client. An intervention in context will be covered as long as the client and family members are both present at the time services are provided. Practitioners in private practice do their own billing; therefore, many hours a week are spent on administrative and organizational activities, telephone calls with insurance companies, medical doctors or other health professionals and documentation of goals and therapy progress.

Being your own boss is a lot of work but the rewards of independence in running your own business can be worth all the effort. Private practices are **not as common** in the US as they are in Germany because the health insurance system in the States is very different. Unfortunately, many people have no health insurance at all and cannot afford treatment.

Active Vocabulary: Working in Private Practice

What are the English equivalents of the expressions listed below? They are all used in the above text.

- Abrechnung, Rechnungsstellung = _____
- Selbstständigkeit = _____
- ein eigenes Geschäft führen = _____
- sich etwas leisten = _____
- rollstuhlgerechter Zugang = _____
- Teilzeit- = _____
- Therapieziele = _____
- unter Vertrag stehender Leistungserbringer (Kassenzulassung) = _____

Additional info online

Discussion

What is typical of working in a private practice in the USA? Compare the information given in the text to your own knowledge of this type of work in Germany.

3.9 Working for a School Board in the USA

After I finished my professional training as a speech and language therapist (SLT), I decided to do an **internship in the USA**. I was interested in learning how SLTs worked in other countries since I knew that it was quite different from Germany sometimes.

I did a four-week internship at a pre-school and elementary school, which means that I worked with children aged 4 to 10. The two SLTs at the school with whom I did my internship worked in the **special needs department** together with an occupational therapist and specially trained teachers. The special needs department supported children with learning disabilities such as dyslexia, non-verbal learning disabilities such as Attention Deficit (Hyperactive) Disorder (ADD/ADHD) and neuromotor disorders such as cerebral palsy.

The model of service-delivery intervention that was adopted by the SLTs and special needs department was either one of the following two types or, on occasion, a combination of both: 1) itinerant or 2) consultant.

Itinerant services
Itinerant services meant that the students were seen directly by the SLT and received traditional speech and/or language intervention. For example, in the elementary school a part of our day was spent attending class with the students. We provided **curriculum-related intervention**, that is, training that assisted the special needs students in keeping up with the demands of the class and their peers. When they had texts to write we helped them phrase their sentences. When the other children in class were doing quiet work we completed easier and shorter reading exercises with them. Individual, or one-on-one, classroom therapy did not account, however, for all of the direct service time. Sometimes group therapy was also offered and therapy in groups of two to six was given in our individual offices.

In the case of our pre-school caseload, **individual therapy** was extremely limited and took up the least part of our day. We visited the pre-school three times a week and a child might have received only 15 or 30 minutes of therapy per visit. **Group therapy** was most common in the pre-school. We ran programmes such as the "alphabet programme" to increase phonological awareness and pre-literary skills. The sounds were not taught in alphabetical order but rather were dependent on sound classification (e.g., "lip sounds" like /p/, /m/, or /b/ were taught first and "teeth sounds" like /t/ or /d/ were taught second). Each sound of the alphabet had a designated name (e.g., /f/ was the "angry cat sound"), and each had a related story, poem or activity that we could practise with the students.

Consultant Services
Consulting or collaborating with parents and teachers took up most of our time. In the case of pre-school children, parents were counselled and encouraged to implement home programmes. In the elementary school, it was often the teacher who identified a student having problems in class and suggested that he or she required individual help from the special needs department. In these situations an assessment was needed and we

administered a test, for example, a test for receptive and expressive vocabulary. If the student required therapy, the SLT would then meet with the special education teacher to design and implement a specific intervention plan with goals to be targeted in class.

Advantages and Disadvantages

On the one hand I was impressed by the integrated nature of the special needs department: it was a normal elementary school for children with special needs, not a special school for children with learning disabilities. The teachers worked together very well with the therapy staff and tried to meet the individual needs of the students. On the other hand, it was often difficult to justify to oneself the lack of individual therapy that was provided overall. This was most concerning because we knew that effectively most of these children with learning disabilities did not receive additional therapy outside of our school.

Active Vocabulary: SLT in a School Setting

Additional info online

The English equivalents to these German words are used in the text. What are they?

- den Unterricht besuchen = _____
- Einzeltherapie = _____
- Eltern beraten = _____
- expressiver Wortschatz = _____
- Grundschule = _____
- Gruppentherapie = _____
- Konsulardienst, Beratungsdienst = _____
- Legasthenie = _____
- Lehrplan = _____
- Lernbehinderungen = _____
- mobiler Dienst = _____
- neuromotorische Störungen = _____
- Praktikum = _____ (AE)
- rezeptiver Wortschatz = _____
- Vorschule = _____

Excercise

In North America, school boards are important employers for OTs and SLTs. Do some research to find more information on this type of work.

Discussion

1. **What are the possible advantages and disadvantages of the school organizing the delivery of therapy rather than making this the parents' responsibility?**
2. **Is it possible for OTs, PTs and SLTs to work for a school in Germany, too? Can you think of current trends and future developments?**

3.10 Working in a Hospital in the USA

As in a private practice situation, the hospital setting requires multi-task management, flexibility, occupation-based therapeutic skills and competence in the documentation of evidence-based practice.

For example, a typical day for an occupational therapist **in a psychiatric hospital** would begin with a team meeting of OT staff members and the OT supervisor to check attendance, plan the day and assign new patients to therapists or group activities. Some patients come into the OT department for individual therapy and some therapists go to various wards in the hospital (e.g., to the children's ward or to the adult locked ward, etc.) for ADL training, individual or group therapy activities. In the afternoon there might be an activity group led by an occupational therapist or a certified occupational therapy assistant (COTA) in the OT department for various patients to do leather work or arts and crafts. A visit to the near-by shops to practise communication and interaction skills with a patient about to be released from the hospital could also be on the schedule. Once a week, an OT might co-lead a self-confidence training group with a psychologist for in- and outpatients with alcohol- and drug-addiction problems. At the end of the day, the occupational therapists return to their office to document diagnostic procedures, behavioural observations, incidents that might have occurred during intervention, and/or therapeutic progress. Often when the work with patients is over and the documentation is done, there is time for researching the internet for evidence, reading professional literature or discussing cases.

A typical day for an occupational therapist **in a rehabilitation hospital** is another example of a hospital setting, and is structurally very similar. In a rehab setting, therapists often go to patients with strokes or spinal cord injuries in their rooms on the ward in the early morning for ADL training in collaboration with the nursing staff. Ambulatory patients or patients in stryker frames or wheelchairs come to the OT department for sensory, perceptual, neuromuscular, or cognitive training, according to individually set goals. Engagement in occupation is just as important in this setting as in other settings with the general goal to enhance participation in life. Assessment, design, fabrication, application, fitting and training in assistive technology, adaptive devices and orthotic and/or prosthetic devices often keep an OT in rehab busy during a full workday. In a rehab hospital, modification and adaptation of environments and equipment, including ergonomic principles at h ome, work, school, or in the community form an important part of OT services. Driver rehabilitation and community mobility is often included in this setting as an intervention goal. Participation in weekly ward visitations with the medical doctors, nurses and other therapists, as well as participation in counselling services for family members and caregivers, are equally important areas of OT practice. An occupational therapist in a rehab hospital is part of a comprehensive team of medical, psychological and social professionals, who together are all promoters of health and wellness for their patients, enabling performance in everyday life activities in individual cultural, physical, environmental, social, and spiritual contexts.

Active Vocabulary: OT in a Hospital Setting

Additional info online

The English equivalents to these German words are used in the text. What are they?

- Alkoholabhängigkeit = _____
- ambulant = _____
- anpassen = _____
- auf dem Programm stehen = _____
- die Anwesenheit überprüfen = _____
- Drogenabhängigkeit = _____
- eine Gruppe leiten = _____
- geschlossene Station = _____
- Kunsthandwerk = _____
- Lederarbeiten = _____
- Mitarbeiter = _____
- Schauplatz, Rahmen = _____
- Selbstbewusstsein = _____
- Stationsbesuch = _____
- übergeben, zuweisen = _____
- Werkgruppe = _____

Questions

1. **What activities do OTs do in a psychiatric hospital? Compare these to your own experience: What activities are typically done with psychiatric patients in Germany? Differentiate by patient groups.**
2. **What activities are OTs concerned with in a rehab hospital? Compare these to your own experience – what activities are typically done with rehab patients in Germany?**
3. **What are the typical professional duties of PTs and SLTs in the hospital setting? Compare the experiences of the three professions. Are these completely diverse, do they complement each other, or is there a duplication of skills? What are the areas of multi-professional teamwork?**

3.11 The Multi-Professional Setting within a Hospital in the United Kingdom

Additional info online

AHPs often work in acute general hospitals and specialized or rehabilitation hospitals.

In their everyday working life they deal with a variety of different professions or supportive departments which form an important part of the multi-professional health care team. Each of these professions or supportive departments forms an independent department and is needed in order to provide good service in the patient care units.

Exercise

Below you will find a list of activities relating to some of these professions. Match the correct number to the appropriate box at the end of the answer. The first one has already been done for you as an example.

Who do you contact…

1. … if you need to find out about your patient's blood results taken the other day?
2. … if you need to arrange for follow-up medication for your patient who has a prescription or if you need a new hand disinfectant for your department?
3. … if you need to look up an old patient chart to see how a patient was previously treated?
4. … if you need to find out whether your patient suffers from a lung consolidation or a rupture of a knee ligament such as ACL?
5. … if you need to arrange new covers for the plinths in your own department?
6. … if you need to find out about what on earth went wrong with your last salary payment?
7. … if you need to find out whether you can take an MRSA patient out of his room to exercise in your rehab department?
8. … if you need to find out about a patient's further management when he is to be discharged from the acute hospital in the near future and will probably require one or two weeks of convalescence?
9. … to have a patient re-assessed urgently as she became ill during a treatment session?
10. … to allay your concerns about a patient's condition regarding aspiration problems as you consider him unsafe to feed himself independently?
11. … to have a BKA patient exercise his stump with a pressure device?

(A) The lab (laboratory) examines and evaluates blood samples as well as other kind of body secretions such as urine and phlegm. [1]

(B) The Radiology/X-Ray Department carries out X-rays for in- and outpatients as well as x-rays in ICU and in some cases MRIs and CTs. [__]

(C) The liaison nurse or Social Services Department handles all personal matters of the patient such as home situation, the need for home help or "meals on wheels" as well as organizing places in nursing homes or a period of rest when discharged from hospital. [__]

(D) The Dieticians' Department looks after every patient's nutrition status individually and is involved in decisions on further nutrition management. [__]

(E) The Payroll Department deals with each employee's salary as well as additional income from e.g. weekend work and with wage statements or wage slips in general. [__]

(F) The pharmacy attends to the supply of medication for in-patients, with follow-up hospital discharge medication and the supply of medical means to other departments. [__]

(G) The orthotist or Orthotics Department deals with the supply of individually fitted insoles and shoeware in general as well as different devices for amputees. [__]

(H) The infection control nurse deals with all matters regarding hospital hygiene such as infection control lectures for employees, infection control audits as well as individual patient care. [__]

(I) The Medical Records Department keeps files of all patient data such as ward charts, progress reports and discharge letters plus other documents such as X-rays and medical opinions. [__]

(J) The A & E Department cares for all urgent cases, mainly "walk-in patients" or RTA victims usually brought in by ambulance. [__]

(K) The Stores provide a wide range of additional supplies for different departments, such as bed linen, hand towels, pillow and bed covers etc. [__]

Active Vocabulary: Types of Hospital Wards

Please match the German expressions with their English equivalents. The first one has already been done for you as an example.

1. general ward	A. Ambulanz
2. surgical ward	B. Aufnahmestation
3. medical *or* internal ward	C. Beobachtungsstation
4. emergency ward	D. Chirurgische Station
5. children's *or* paediatric ward	E. Entbindungsabteilung, Wöchnerinnenstation
6. nursing ward	F. Innere Abteilung
7. psychiatric ward	G. Intensivstation
8. oncology ward	H. Isolierstation
9. isolation ward	I. Kinderstation
10. accident *or* casualty ward	J. Normalstation
11. maternity ward	K. Notaufnahme
12. ambulatory care ward *or* acute day ward	L. Onkologiestation
13. intensive *or* critical care ward	M. Pflegestation
14. admission ward	N. Psychiatrische Station
15. observation ward	O. Sterbestation
16. terminal ward	P. Unfallstation

3.12 Asking and Giving Directions

Exercise

Please fill in the gaps by using the prepositions listed in the table below. The number in brackets tells you how often they may be used:

above (1)	at (4)	behind (1)	down (2)	for (3)
from (1)	in (3)	of (2)	on (4)	through (1)
to (8)	up to (2)	with (2)		

Mrs Johnson has her first appointment _____ (1) the Northwest Cascades Rehabilitation Centre following her surgery _____ (2) arthritic joints _____ (3) her hand. She comes _____ (4) the reception desk _____ (5) her referral and appointment card.

Mrs Johnson: Good morning! I am Mrs Johnson and I have my first appointment _____ (6) a therapist today somewhere here _____ (7) this centre.

Receptionist: Good morning, Mrs Johnson. Do you know what kind _____ (8) therapy the doctor prescribed? Please give me your referral _____ (9) your doctor and your appointment information.

Mrs Johnson: I believe I have an evaluation _____ (10) the occupational therapy department.

Receptionist: Yes, you have a referral _____ (11) the OT-department _____ (12) splinting and an initial functional evaluation. You will be seeing Kathy Thompson, an occupational therapist, today. I will call the department and announce your arrival. You may proceed _____ (13) the OT-department. Kathy will meet you _____ (14) the door.

Mrs Johnson: Thank you _____ (15) your assistance. Now, how do I find the OT-department?

Receptionist: You go straight _____ (16) this hall _____ (17) your left. You will pass the x-ray rooms and an emergency room. _____ (18) the end _____ (19) the corridor, there is a lift, which you can take _____ (20) the third floor. Then you take a sharp turn right _____ (21) the double doors. There is a sign _____ (22) these doors that says "Therapeutic Services". Go _____ (23) the doors, straight _____ (24) the hall _____ (25) a wide opening, where there are three coloured doors: red, green and blue. The blue door _____ (26) the right is the entrance _____ (27) the OT-department. It has a sign "Occupational Therapy Department" _____ (28) the door. Kathy will meet you _____ (29) the reception desk just _____ (30) this blue door.

Mrs Johnson: Thank you _____ (31) the directions. I hope I find the blue door!

Receptionist: There is a blue line _____ (32) the floor to follow _____ (33) the OT-department too, in case you get disoriented and you may ask anyone _____ (34) the way. Have a good day and we will see you next time!

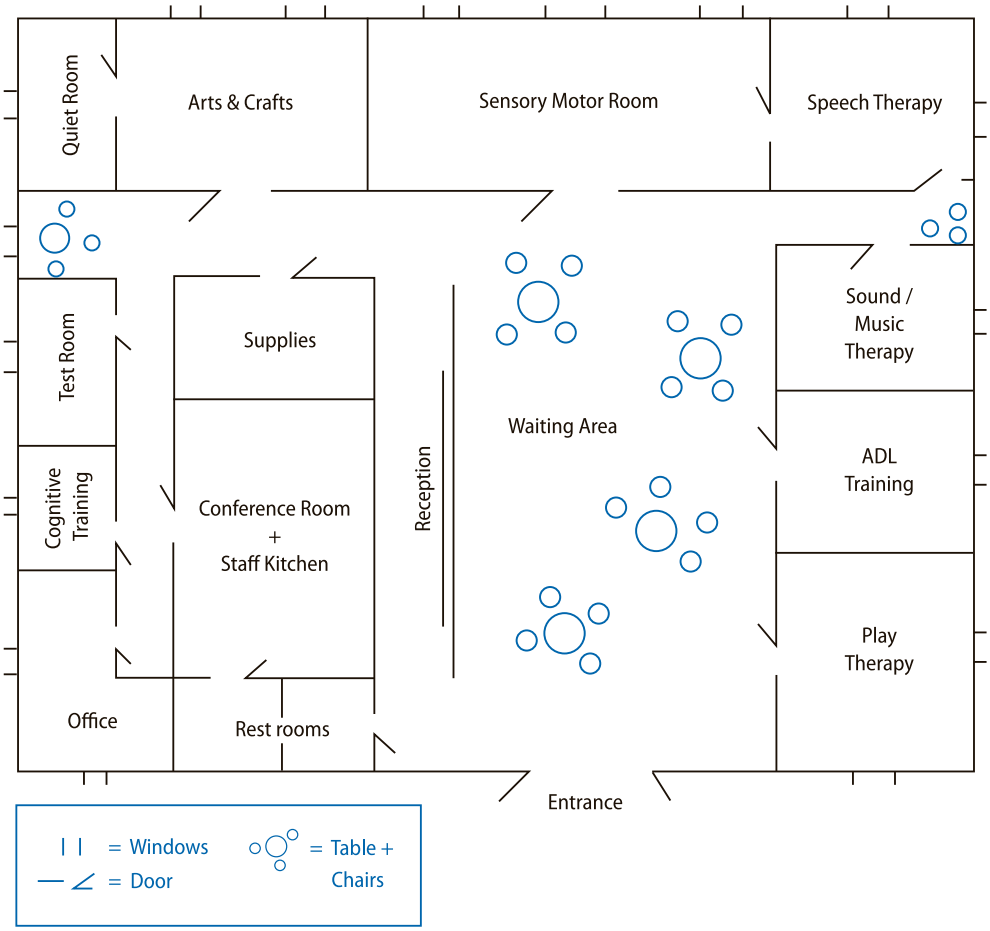
Active Vocabulary: Asking and Giving Directions

How do I get to ...?	Wie komme ich nach/zu…?
What's the best way to ...?	Wie ist der beste Weg nach/zu…?
Where is ...?	Wo ist…?
Go straight on (until you come to ...).	Gehen Sie geradeaus weiter (bis Sie zu … kommen).
Turn back./Go back.	Kehren Sie um.
Turn left/right (into…).	Biegen Sie nach links/rechts ab (in…)
Go along	Gehen Sie … entlang.
Cross ...	Überqueren Sie ….
It's on the left/right.	Es ist links/rechts.
straight on	geradeaus
opposite	gegenüber
near	in der Nähe von
next to	neben
between	zwischen
at the end (of)	am Ende (von)
on/at the corner	an/in der Ecke
behind	hinter
in front of	vor
(just) around the corner	(einfach) um die Ecke

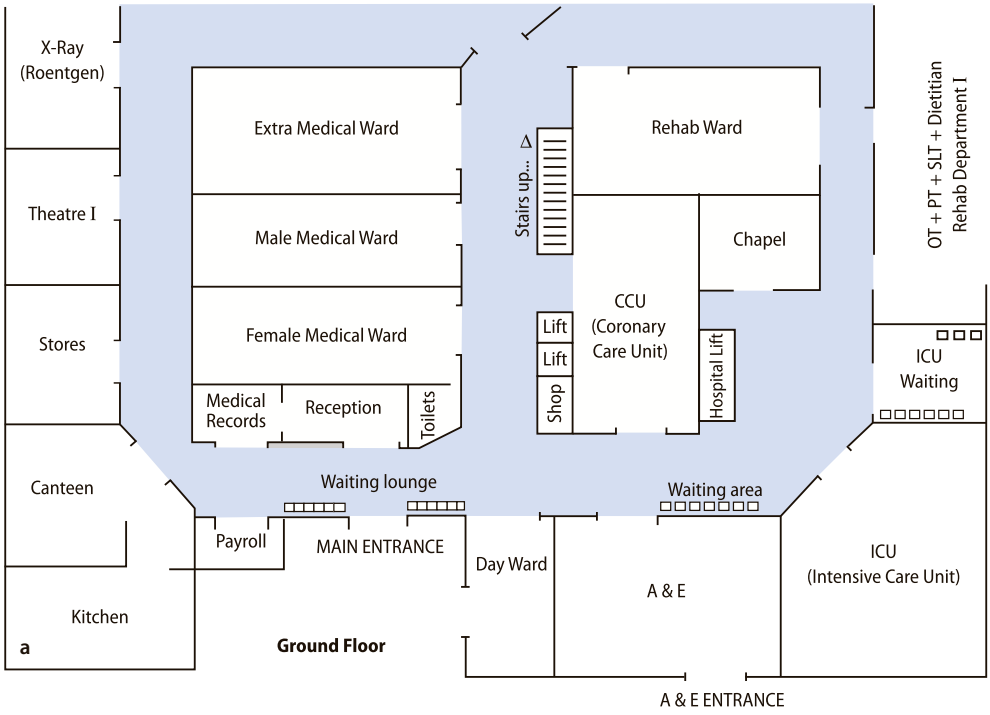
Simulation Task

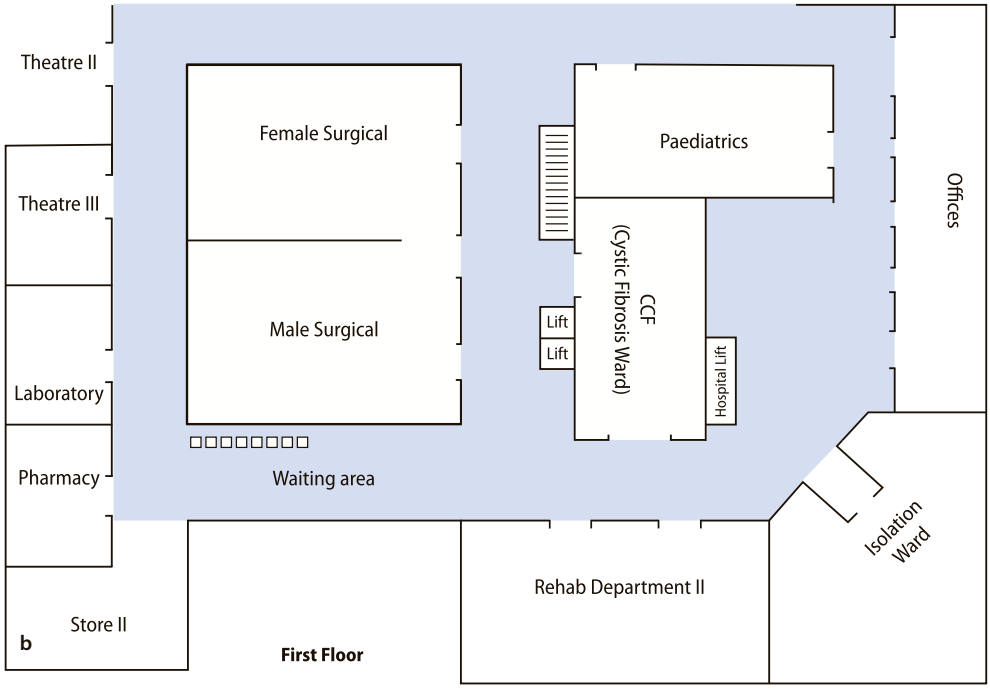
Get together with a partner and practise asking and giving directions by using the floor plans provided on page 78 and 79. Take turns being a client or a new colleague asking the way to a particular room or department and the receptionist, who explains the way.

Floor Plan OT and SLT Practice (Example from the USA)



Hospital Floor Plan (Example from the UK)





3.13 Working Shifts for Allied Health Professionals in Public Hospitals

In the United Kingdom, AHPs generally work a 37.5 hour week. In the Republic of Ireland, the working week is 33 hours. Occupational therapists and speech and language therapists work a five-day week only (Monday to Friday). Physiotherapists' working shifts vary depending on the care they provide. Their normal working time is also from Monday to Friday, however, in some cases they provide weekend services and on-call services, which include weekend and night duties.

Journalist Yvonne Atkins from *The Weekly AHP Gazette* is doing some research for an article on the work conditions of physiotherapists. She asks Patrick (a Senior II physio), Marcio (a Junior physio) and Jasmine (a Senior I physio) what they do for their weekends at work.

Yvonne: Patrick, can you describe how your weekend work is organized?

Patrick: Well, as you know I work in an acute general hospital, which also offers elective orthopaedic surgery. This means that physiotherapy services are provided on Saturdays and Sundays and each physio staff member is on a weekend rota list. On Saturdays I usually start at 9 a.m. and I would usually go to ICU first and treat the patients there. This way I can organize my day more efficiently and see some patients again in the afternoon, if they need to be seen twice a day. On Saturdays and Sundays I will treat chest patients, who have been put on the weekend patient list by the physios on the wards on Friday or otherwise have been newly referred by the doctors. Orthopaedic patients are seen on Saturdays only; this is for "day one" patients only, though.

Yvonne: What does that mean?

Patrick: What I mean by that is that only patients who had their orthopaedic surgery the Friday before will be mobilized on Saturdays, as it will be their first day out of bed (day one). It is the policy in our hospital that each orthopaedic patient must be mobilized by a physiotherapist before mobilizing with other staff members, such as nurses, for instance. Once I have seen all the orthopaedic and chest patients I will go back to ICU and after that I will go home. Fortunately, there is no on-call service provided in our hospital.

Yvonne: Well, thanks a lot for all this information, Patrick. Marcio, as I understand, your Physiotherapy Department provides on-call services. Can you tell us about it?

Marcio: Sure. "On-call service" means that physiotherapy services are provided when indicated and generally requested by a doctor or ICU nurse outside the normal working hours, like 5 p.m. to 9 a.m., for example. I was on call last week for instance. This means that I have to be available and free to respond to a call during the on-call period. Before you participate in on-call duties you will have to have completed a respiratory rotation and have

worked in ICU. Your senior physiotherapist will assess your skills and competences with you. You must feel and be competent to provide on-call services, as you are kind of on your own and you are responsible for very seriously ill patients. You should also familiarize yourself with patient referral criteria, department policies, health and safety issues and response time, for example. Last week for instance I was on call and had to come in twice during the night to treat patients in the Intensive Care Unit. I was really tired the next morning, but anyway you still have to be back at work in the morning for your normal weekly work. If you are interested in emergency physiotherapy – as on-call service is also known – you can read the book Emergency Physiotherapy – On-Call Survival Guide by Beverley Harden. I can really recommend it to anyone who is on the on-call rota.

Yvonne: This is really interesting, thank you, Marcio. Now Jasmine, what about yourself – do you do weekend work or on-call physiotherapy?

Jasmine: No, thankfully, I do not have to work nights or weekends anymore. See, in the UK in general, only Junior and Senior II physiotherapists do weekend or on-call work. There are, of course, exceptions, but usually Senior Is work Mondays to Fridays in the daytime only. I know that in the Republic of Ireland, however, even specialized senior physiotherapists have to work at least two weekends a year to maintain their skills.

Active Vocabulary: Working Shifts

Additional info online

The English equivalents to these German words are used in the text. What are they?

- am Wochenende arbeiten = _____
- Arbeitsschicht = _____
- Arbeitswoche = _____
- Arbeitszeit = _____
- Bereitschaftsdienst = _____
- Fünf-Tage-Woche = _____
- Nachtdienst = _____
- nachts arbeiten = _____
- Wochenenddienst = _____
- Wochenenddienstplan = _____

Question

What are the duties of physiotherapists who provide weekend or on-call services?

Discussion

Are the working shifts for AHPs in Germany similar to those in the United Kingdom and in the Republic of Ireland? What are the advantages and disadvantages of providing on-call services?

Additional info online

Note

There is a list of instruments and materials frequently used in OT, PT and SLT treatments in the Appendix.

3.14 Instruments and Equipment in the Hospital

Exercise

Here is a list of instruments, items of equipment and other objects frequently encountered in the hospital setting. In each set of words one is the odd one out, i.e. different from the others. Find the word that is different and circle it. The first one has already been done for you as an example.

1	examination couch	commode	gurney	operating table
2	blood pressure cuff	ruler	thermometer	calipers
3	tourniquet	plaster	dressing	cast
4	overhead trapeze	bedrails	footboard	drip stand
5	foam cushion	pad	bed linen	pillow
6	medical record	bandage	lab slip	chart
7	scalpel	forceps	tongue blade	beeper
8	indwelling catheter	leg bag	GI tube	nasogastric tube
9	headlight	laryngeal mirror	stethoscope	ophthalmoscope
10	sling	scrubs	apron	gown
11	syringe	crash cart	hypodermic needle	cannula

3.15 Health and Safety in the Hospital

Manual Handling

Each health care professional and health care staff member working in the United Kingdom or the Republic of Ireland has to attend manual handling lectures on a regular basis.

The aim of manual handling courses is to make participants aware of health and safety at work and its importance whilst caring for clients. It also aims to provide health care staff with skills and knowledge necessary for **safer load** and **client handling**. At the end of a manual handling course the participants will be able to outline relevant legislation and be aware of employer's and employee's responsibilities. They will be able to list factors contributing to back pain and apply risk assessment processes. They will also be able to explain and apply principles of safer handling as well as discuss health issues and dilemmas in a professional manner.

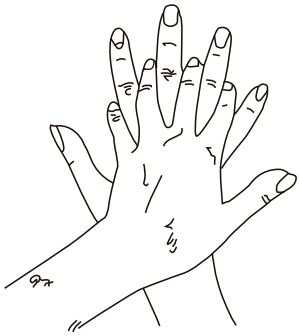
Usually, one common question during job interviews for AHPs relates to health and safety issues and the manual handling techniques of the applicant. When questions are asked about health and safety it usually involves not only the patient's, but also the therapist's safety, safety knowledge and skills.

Infection Control

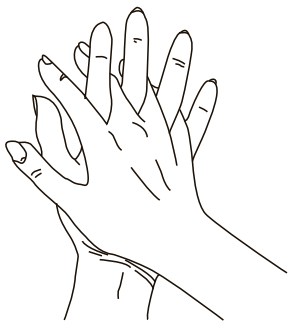
20 The term infection control describes measures practised by health care staff in health care settings with the aim of reducing the transmission and acquisition of infectious agents. These measures include **hand hygiene**, **protective clothing** and regular health care staff education and **infection control lectures**.

Diagram of the Right Hand Washing Technique (should last 10 – 15 seconds)

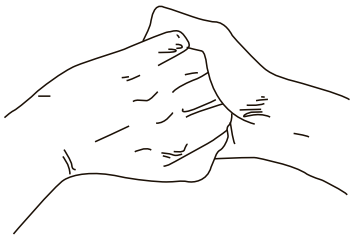
1 Palm to palm



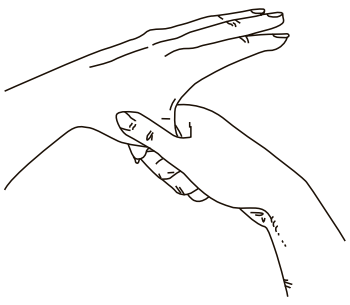
2 Right palm over left dorsum and left palm over right dorsum



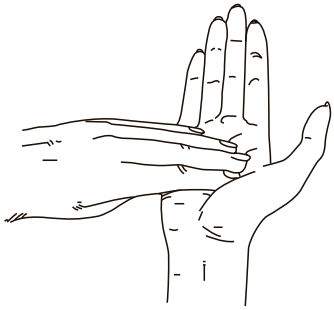
3 Palm to palm fingers interlaced



4 Backs of fingers to opposing palms with fingers interlocked



5 Rotational rubbing of right thumb clasped in left palm and vice versa



6 Rotational rubbing backwards and forwards with clasped fingers of right hand in left palm and vice versa

MRSA

Extract of the Working Well Initiative by the Royal College of Nursing, Belfast:
MRSA stands for **methicillin-resistant staphylococcus aureus** – an organism that colonizes the skin, especially the anterior nares (nostrils), skin folds, hairline, perineum and umbilicus. It usually survives in these areas without causing infection – a state known as colonization. A patient becomes clinically infected if the organism invades the skin or deeper tissues and multiplies to cause a localized or systemic response, for example septicaemia.

Staphylococcus aureus has shown an ability to resist antibiotics for the last 40 years. Strains of the organism differ in their sensitivity to antibiotics. When there is a resistance to methicillin, the bacterium is labelled MRSA. Some MRSA strains known as epidemic strains or EMRSA are likely to spread.

The consequences of developing a serious infection with MRSA can be severe, as the range of effective antibiotics is limited and expensive and they can be toxic. It is therefore important to take precautions and stop MRSA from spreading.

MRSA is transmitted in two different ways, endogenously and exogenously. **Endogenous spreading** is transmitted by affected patients themselves where they spread the bacteria from one part of their body to another. The patients should therefore be encouraged to wash their hands and stop touching their wounds. **Exogenous spreading** of MRSA is transmitted from person to person. This happens by either direct contact with affected skin areas or via a contaminated environment or contaminated equipment. Skin scales can contaminate if they become airborne, for example during bed making activities.

With MRSA patients, vital **precaution measures** must be taken:

- hand washing and hand disinfection after contact with MRSA patient
- apply topical treatments to reduce skin transmission
- keep the environment clean
- keep patients in isolation or on MRSA wards
- wear aprons or gowns and gloves
- wear a face mask if MRSA is localized in the nostrils (if chest physiotherapy required, for example)

In order to deal with MRSA patients in a responsible manner all health care staff must be able to carry out the appropriate hand washing and hand disinfecting techniques. Infection control nurses will often check on all hospital staff's ability to perform adequate hand washing.

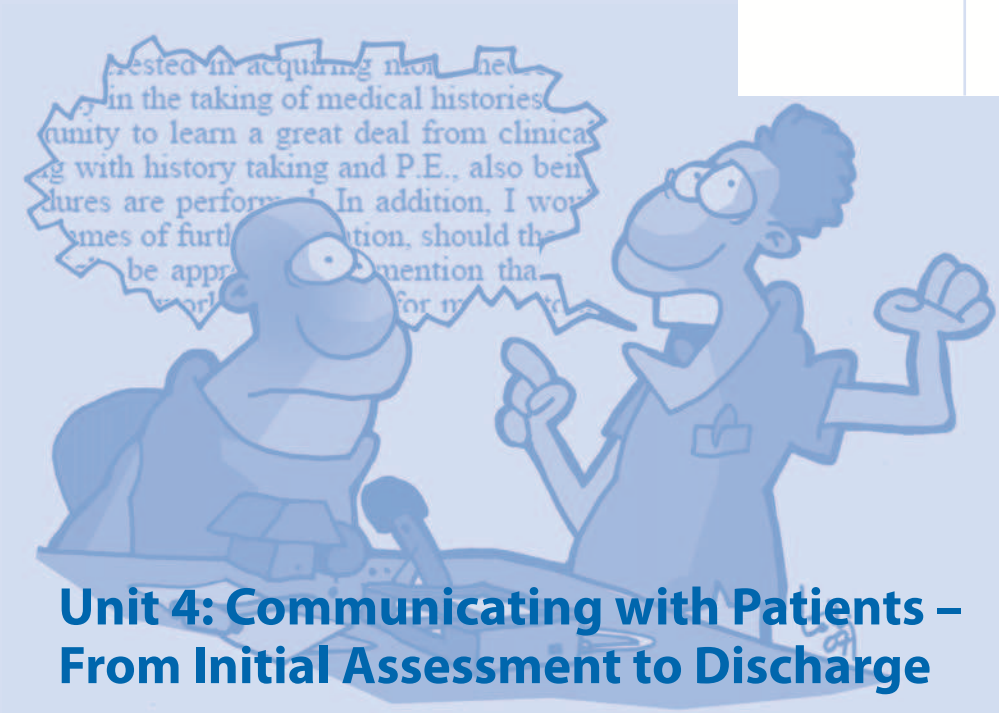
VRE

The Term VRE stands for **vancomycin-resistant enterococci bacteria**, which are normally found in the intestinal tract. They can sometimes be pathogenic and develop resistance to vancomycin, a powerful antibiotic. VRE, just like MRSA, is NOT dangerous to healthy people with good immune systems. In healthy individuals the intestine flora keeps VRE under control. VRE is a serious threat to sick people as it cannot be controlled with antibiotics and can cause life-threatening infections. It is especially dangerous as VRE can easily transmit the resistant genes to other bacteria such as staphylococci or streptococci. Transmitting and spreading are the same as with MRSA, i.e. by contact with contaminated persons or objects.

Questions

1. What does MRSA stand for?
2. Where does it usually colonize?
3. When is staphylococcus aureus considered MRSA?
4. Why is it difficult to treat MRSA?
5. How is MRSA transmitted?
6. How long should a health care professional wash his or her hands?
7. How many steps does safe hand washing involve?
8. What is VRE?
9. What are the aims of manual handling courses?

4



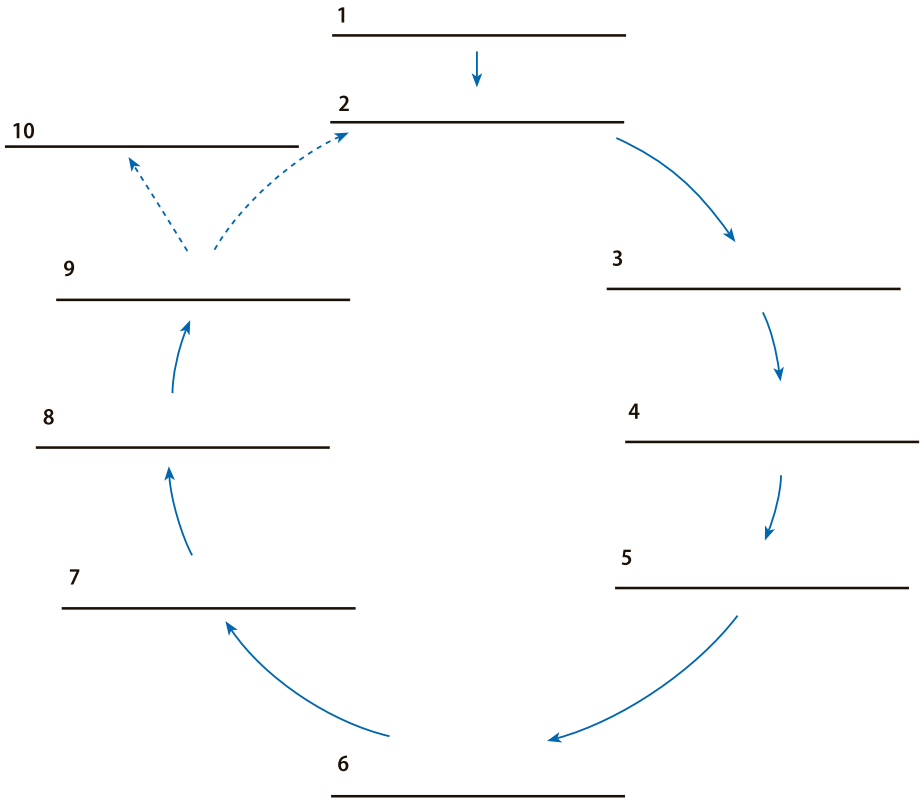
Unit 4: Communicating with Patients – From Initial Assessment to Discharge

4.1 The Therapeutic Relationship and the Intervention Process

The intervention process of the professions of occupational therapy, physiotherapy and speech and language therapy includes taking a client history, initiating assessment procedures, setting client-centred goals, providing treatment and evaluating the client's progress. Of course, differences occur in the execution of the individual tasks required of the various professions. A client history, for example, will differ according to whether it was taken by an occupational therapist, a physiotherapist or a speech and language therapist. Since the aims of these three professions and their therapeutic interventions are different, the information needed for a meaningful and effective treatment plan differ as well.

Exercise

1. **Give an example of the therapeutic process in your own profession and then compare it with that of a fellow student from another profession. What differences and similarities do you find?**
2. **Here is a diagram of the therapeutic process in occupational therapy according to Hagedorn (1997). Please arrange the steps listed in the table below in the right order.**



(a) evaluating result	(f) terminating the treatment
(b) collecting information, assessing client's needs	(g) planning the treatment
(c) referral	(h) reviewing the outcome, changing treatment if necessary
(d) discharge	(i) providing treatment
(e) deciding on treatment goals with the client	(j) analysing information

4.2 Making an Appointment

In an outpatient setting, the interaction between client and therapist usually starts with the client asking for an appointment.

Doris Elliott was in a car accident three months ago and was an inpatient for three days due to mild injuries to her face and left lower rib cage. For about two weeks she has complained of back pain and that she is unable to carry out some of her ADLs, such as hoovering or cooking meals. Her GP has referred her for outpatient physiotherapy and Doris is about to ring the physiotherapy department of her local acute general hospital.

Secretary: Department of Rehabilitation, Riverside Hospital, how can I help you?

Doris: Hello, my name is Doris Elliott and I would like to make a physiotherapy appointment. I sent you my GP referral three days ago.

Secretary: Hang on a minute… yes, Doris, I have an appointment here with Jasmine, one of our physiotherapists. A week on Tuesday at 3.30 p.m., would that time suit you?

Doris: Yes, that's great, thank you very much. I'll be there. Bye now.

Secretary: Bye, bye.

Active Vocabulary: Referring to time

The days of the week and the months are written with capitals.

Use **on** for days and dates

- on Friday
- on the 1st of July *or* on July 1st

12/5/2007 means "12 May 2007" in the UK but "December 5, 2007" in the USA

Use **in** for longer periods (months, years, seasons)

- in June, in 2007, in the winter
- in the morning, in the afternoon, in the evening

Use **at** for precise times
- at 10 a.m., at 4 p.m.
- **at** is also used for the following expressions: at night, at the weekend, at Christmas, at the moment

Time:
- 9.00 = 9 o' clock

4

Note

"o' clock" is only used for the full hour

- 9.15 = (a) quarter past 9
- 9.30 = half past nine
- 9.45 = (a) quarter to ten
- at exactly 3 o' clock, at 3 sharp, at 3 on the dot (um Punkt drei Uhr)
- at around 5 o' clock (ungefähr um 5 Uhr)

Simulation Task

Get together with a partner and practise making an appointment.

Additional info online

4.3 Case History

Exercise

Some important words are missing from the explanation below. Please fill them in by using the correct forms of the verb and by using the plural where appropriate. The first one has already been done for you as an example.

admission	to establish	interview
chart	focus	to occur
~~to collect~~	to gather	participation
context	habit	profile
engagement	intervention	to take

The first step in the therapeutic process is collecting (1) essential information about the client, his or her living circumstances, preferences, _____ (2), problems and goals. This step is known as _____ (3) a case history or client history. The case history is the complete medical, family, social, and psychiatric history of a client up to the time of _____ (4). It usually begins with a review of the client's _____ (5) or file for demographic information and medical information. The following initial _____ (6) with the client contributes further to the _____ (7) of information for a complete case history.

In occupational therapy, the term "occupational profile" is used for case history, specifying the profession's unique _____ (8) on occupation. According to Youngstrom et al. (2002), the major focus of occupational therapy is to support _____ (9) in context through _____ (10) in occupation. An

individual's experience and performance cannot be addressed without understanding the many contexts in which occupations and daily activities _____ __ (11). The occupational therapist sees the client contextually, i.e. a client's engagement in occupation occurs in a variety of _____ (12) (cultural, physical, social, personal, temporal, spiritual, virtual). It is therefore necessary to consider all the aspects of a client's daily life by _____ (13) an occupational _____ (14) before planning _____ (15) in collaboration with the client.

Information to be derived from chart review and/or interview:

- date of birth / age
- current or admitting diagnosis
- birth history (in paediatrics)
- past medical history (including family history)
- cognitive status
- medications
- laboratory investigations
- functional history (ambulation, mobility, regular exercise etc.)
- social history (occupation, leisure activities, living arrangements, help at home)
- prior treatment
- patient goals
- established structured questionnaires (e.g., depression scores, health-related quality of life questionnaires, functional status questionnaires, mini-mental or perceptual status, patient satisfaction)

(cf. Reid & Chung, 2004)

Active Vocabulary: Case History

The English equivalents to these words are used in the list above. What are they?

- aktuelle Diagnose/Aufnahmediagnose = _____
- Anamnese der Vorerkrankungen =_____
- Fragebogen = _____
- frühere Behandlung =_____
- funktionelle Anamnese = _____
- Geburtsanamnese = _____
- Geburtsdatum = _____
- Medikation = _____
- Patientenakte = _____
- Patientengespräch = _____

4.4 The Initial Assessment Interview – Basic Interview

Taking a history most commonly involves the therapist interviewing the client and possibly his or her relatives or significant others. According to Hegde (1996), the interview is a face-to-face contact with the client, the parents, the children, the partner, the power of attorney and/or the substitute decision-maker. It is the goal of the therapist to obtain additional information, to have information given on the printed case history form clarified or expanded, to become familiarized with the client, the family and/or other, and to make initial observations of the client, the family and/or other.

Exercise

Take a look at the following example of an initial assessment interview between a physiotherapist and her client. The following prepositions have been left out for you to fill in:

after	after	at	by	down	during
during	during	during	for	for	for
for	for	forwards	from	in	in
in	in	in	in	in	of
of	of	of	of	of	on
on	on	on	through	to	to
to	to	up	with		

A week after her call to make an appointment, Doris is waiting in the reception area of the physiotherapy department.

Jasmine: Doris, would you like to come _____ (1)? Please take a seat _____ (2) the plinth here. … Now Doris, my name is Jasmine and I am your physiotherapist. My idea for today is that I will take the first initial assessment and ask you lots _____ (3) questions. If we still have time _____ (4) that, I will show you a few exercises. Is that alright?

Doris: Yeah, that's fine.

Jasmine: Your name is Doris Elliott, your date _____ (5) birth is the 24 March 1948 and your occupation is?
(Whilst asking Doris the questions, Jasmine records her answers _____ (6) a special standardized initial assessment sheet.)

Doris: I'm a psychologist.

Jasmine: Ah, very interesting. Any hobbies?

Doris: Golf and horse riding.

Jasmine: Oh, that's nice. So, Doris, tell me what your problem is. Why are you here?

Doris: Well, I was _____ (7) a car crash about three months ago and hurt my chest and face.

Jasmine: When exactly was that?

Doris: _____ (8) the 23 July 2008.

Jasmine: _____ (9) your x-ray results I can see there were no fractures.

Doris: That's right. My chest and face were severely bruised though. I still find it a bit difficult to take a deep breath.

Jasmine: Well, your face certainly looks better now. You can hardly see anything anymore. Where abouts does your chest hurt?

Doris: Here. *(She points _____ (10) her left lower rib cage)*
I also find it difficult to turn my upper body _____ (11) the left or right and often _____ (12) the night or _____ (13) the evenings I have back pain. I find it difficult to hoover or cook the dinner, both activities give me back pain and I have to sit _____ (14) and rest _____ (15) a while…

Jasmine: Okay, so you mentioned you have pain _____ (16) the night. Do you wake _____ (17) _____ (18) the night because of pain?

Doris: Sometimes, only if I have done a lot the day before.

Jasmine: What do you do to ease the pain?

Doris: I take painkillers, paracetamol. One usually does the job.

Jasmine: Anything else that would ease the pain?

Doris: Not that I know of.

Jasmine: So what aggravates the pain?

Doris: Movement, bending _____ (19), for example…

Jasmine: Can you describe your pain to me? What kind _____ (20) pain is it?

Doris: Well, it is more a soreness, really, kind _____ (21) an achy pain, you know?

Jasmine: _____ (22) a scale from 0 – 10, where 0 is no pain and 10 is the worst pain ever, how would you grade your own pain? See this ruler here *(VAS scale)*, push the little curser _____ (23) whatever number applies.

Doris: I think it would be about 6.

Jasmine: 6, okay… Doris, have you ever hurt your back before?

Doris: No…

Jasmine: So your pain is worse _____ (24) the evenings and sometimes occurs _____ (25) the night?

Doris: Yes.

Jasmine: I have to ask you a few general questions here _____ (26) safety. Do you have any heart problems?

Doris: No.

Jasmine: Diabetes?

Doris: No.

Jasmine: High or low blood pressure?

Doris: Can be quite low sometimes.

Jasmine: Do you require medication _____ (27) it?

Doris: No.

Jasmine: Epilepsy?

Doris: No.

Jasmine: Any metal in your body?

Doris: No.

Jasmine: Lack _____ (28) skin sensation?

Doris: What do you mean?

Jasmine: Well, any numbness anywhere, pins and needles _____ (29) your legs …

Doris: Well, my left foot sometimes feels a bit numb _____ (30) the evenings.

Jasmine: Okay… Any allergies?

Doris: I'm allergic _____ (31) penicillin and cats.

Jasmine: Right. Any other medical conditions?

Doris: No.

Jasmine: Regular medication?

Doris: Only the odd paracetamol at times _____ (32) my back.

Jasmine: Would you say your general health is good?

Doris: Yes.

Jasmine: Have you had any unexplained weight loss?

Doris: *(laughs)* I wish!

Jasmine: Right… Doris, what I am going to do is to have a look _____ (33) your back and the range _____ (34) motion _____ (35) your back and your shoulders and legs. I have to test your reflexes, sensation like hot and cold, sharp and blunt and also general sensation in order to eliminate severe back problems, for example a slipped disc. Do you consent to being assessed _____ (36) me?

Doris: Yes.

Jasmine: _____ (37) the assessment we will discuss a treatment plan and go _____ (38) possible exercises _____ (39) you. Are you all right _____ (40) this?

Doris: Yes, definitely.

Jasmine: Okay, then…

Note

VAS – visual analogue scale, a self-report device or assessment tool that measures the magnitude of pain or mood.

Using the above dialogue, let's have a closer look at some parts of a typical client-therapist interview situation and the types of phrases used in it.

a) Opening

The therapist introduces him- or herself, describes the purpose of the meeting, and indicates how much time the session will probably take. It is important to establish an atmosphere of empathy.

Exercise

How did Doris's therapist introduce herself? Can you think of other ways of doing this? Write these down and then compare them with the list of phrases in the Appendix. Find a partner and practise introducing yourself.

b) Learning about the Problem

The purpose of the initial phase of the interview is to thoroughly discuss the client's history and current status. If the client has already completed a written case history form prior to the interview, the therapist can clarify and confirm relevant information in this conversation.

Clients need to be heard and taken seriously. It is often difficult to talk about problems, weakness, or pain. Therapists can help a client describe his or her situation in detail and specifically, if the questions are formulated well. Open-ended questions and active listening can open doors to important information in planning treatment and help to establish a positive client-therapist relationship.

Asking specific and thoughtful questions and being thorough are important in helping with the assessment or the diagnostic process. Some diagnoses can be ruled out based on the presence or absence of symptoms alone.

Note

While listening to your client's story of his or her problem, it is important to stay attentive and to indicate that you are listening and caring. You can do this by using phrases like "I see", "right", "indeed", "that is interesting", "yes" or "aha". When your client takes a short pause while speaking, you can interject with a question or comment to try to keep the conversation going, but respect silence if and when appropriate.
Note that the use of a short, pertinent or abrupt "yes"/"no" or "hmm", on the other hand, to directly answer a specific question your client has asked may be considered rude.

Active Vocabulary: Types of Questions Commonly Used in the Therapeutic Interaction:

What … is the problem?
Where … does it hurt?
When … did this problem first occur?
Do you suffer from … sleeplessness?
Do you ever … feel like hurting other people?
Have you ever … felt any numbness in your foot?
How long … have you been hoarse?
How much … does the pain affect your activities of daily living?
How bad … is the pain when you bend over?

Exercise

How did the therapist ask about Doris's history of present illness and about her pain? Are there other ways of doing this? Write these down and then compare them with the list of phrases in the Appendix.

Find a partner and practise talking about the present complaint and the experience of pain.

c) Explaining, Obtaining Consent and Providing Reassurance

Making the client feel comfortable is very important in the initial dialogue. The positive development of a client-therapist relationship often depends on the first communicative contact. Sometimes very personal questions need to be asked that would otherwise require a closer relationship. Explanations as to why this information is necessary can reduce embarrassment or anxiety. In asking permission to carry out assessment procedures, for instance, the therapist shows his or her respect for a client's needs and ability to make his or her own personal decisions.

Note

When giving explanations, the language should be kept simple, and no jargon should be used. Use layman's terms as much as possible.

Note

In the process of obtaining consent, practising clinicians must ensure that what they have obtained is "informed consent". That is, consent is valid only when the client has clearly understood the procedure, benefit(s) and risk(s) about to be undertaken. What happens when the client in question has a communication problem or dementia? In some cases the client's nonverbal communication will indicate whether or not he or she agrees to participate. In cases in which this is not possible or uncertainty remains, informed consent needs to be attained from a substitute decision-maker (SDM) or power of attorney (POA).

Exercise

Which parts of the dialogue are concerned with reassurance, explanation and asking for the patient's consent? Can you think of other ways of doing this? Write these down and then compare them with the list of phrases in the Appendix.

Find a partner and practise this part of the interview situation yourself.

d) Closing

In the closing phase, the therapist summarizes the main points from the interview. He or she thanks the client for his or her collaboration and asks if there are any questions or further comments. The therapist also tells the client what the next step is: e.g., doing an assessment, arranging an appointment with a physician or starting therapy.

Exercise

Summarize the patient's main symptoms and give possible treatment options.

4.5 The Initial Assessment Interview – Detailed Interview and Questionnaire

The following is a comprehensive example of a client history interview structure for a paediatric occupational therapy situation. The demographic data, e.g. name, birth date, profession, address, living arrangement, etc., is not included here.

Questions concerning the pregnancy

How old were you (mother) when you were pregnant with this child? Does this child have any brothers and sisters? Did you plan on having children (another child)? Who was planned to be responsible for child rearing (e.g., parents, grandparents, aunt etc.)?
Were you in any way concerned about your health or the health of the baby at any time? Was the pregnancy stress-free or did you experience stressful situations at any time?
Were you (mother) healthy during the pregnancy? Did you work throughout the pregnancy? Did you smoke, drink alcohol or take drugs / medication during the pregnancy?

Questions concerning the actual birth

Was the birth on time, too early or over-due?
How long did the total birth process last? Were the contractions interrupted at any time? Did you receive contraction – facilitation/inhibition meds during the birth process?

Health condition of the baby immediately after the birth

Did your baby suffer from an oxygen deficit or turn blue? Did he/she receive oxygen following birth?
Were there any bruises on your baby's head or body?
Did your baby cry immediately after taking in the first breath of air? Was he/she alert or extremely sleepy and exhausted?
Were you able (or did you choose) to nurse your baby? If yes, for how long?
Any problems with the sucking reflex?

Birth weight _____ ; Apgar value _____ ; pH value _____

Infant development

Has your child ever had attacks of fever, jaundice, meningitis, whooping cough, measles or mumps? At what age?
Any problems with feeding? Does your child have any allergies?
Did your child ever suffer from a head injury?
Does your child hear well? Has he/she ever had ear infections? How often and how serious?
What kind of sleep patterns did your child demonstrate during his/her first six months? What does that look like now at age --?
Does your child show any signs of tactile defensiveness? Does he/she like to cuddle, bathe, and get dried off with a towel, wash hands, face and hair? Does he/she mind getting his/her hands dirty?

▼

Motor development

Did your child crawl? At what age? When could he/she sit and walk independently?
Has your child ever been cross-eyed? Have his/her eyes been checked by an ophthalmologist? Does he/she need glasses?
Does your child move in a coordinated manner? Does he/she have frequent accidents – falling down often or knocking things down?
Does he/she take interest in sport activities? Which ones?
Is your child right-handed or left-handed? Are there any left-handed relatives in the family?

Speech development

When did your child begin to speak?
How is his/her articulation, vocabulary, sentence structure?
Has your child ever stuttered or stammered?
Has he/she persistently spoken words incorrectly (letters incorrectly placed), e.g. instead of "**s**paghetti", "**p**asghetti"? (This is typical for a pre-school child but should not be consistent after pre-school age.)

School abilities

Does your child have problems with concentration?
How did the learning process go for reading, writing, and maths?
What are his/her favourite subjects?
Does your child show motivation to learn?

Social-emotional development

Is your child generally speaking a happy, sad, sceptical or angry child?
Does your child have a specific role in the family?
Does your child have friends?
How is his/her behaviour in group situations, like at parties or at school, church services, family gatherings?
Does he/she have any fears – of animals, people, or specific life-situations?
Does your child like to play? What is his/her favourite game or play situation?
Is he/she playful – are you (mother/father) playful?

General information important for client-centred goal setting and intervention

Has your child had any other therapies previously? If yes, which type of therapy and when?
What would you say is very meaningful or important to your child? What are his/her strengths, i.e. what can he/she do really well?
What are your major concerns about your child's development?
What do you expect from therapy? What did you think of prior therapies?

OT Exercise

Imagine working in a private practice. Today you've scheduled a meeting with a concerned mother. Her 4-year-old daughter displays atypical behaviour at nursery school. She does not take part in fine motor activities such as cutting and drawing and shows deficits in her social behaviour. The mother wants you to help her child. Your first step in therapy is to find out about the child's previous development and her current developmental status.
Following this, you need to find a possible introduction to a narrative interview between the therapist and the mother for the purpose of taking her child's history. Find an interview partner and ask him or her about "his" or "her" child. Take notes on the information provided. For the interview, you may use the suggested introduction or you can make up your own conversation. Remember that it is important to create a pleasant and trusting atmosphere for an interview.

OT: Good morning, Mrs Porter. My name is Angela Richmond and I will be the occupational therapist responsible for your treatment. Would you like a cup of coffee?

Mother: Yes, thank you very much.

OT: You're welcome. So, how may I help you?

Mother: Well, it's about my daughter, Catherine. Her school teacher told me that she avoids doing handicrafts and that she doesn't play well with the other children in her class. I don't know what's wrong with her, at home I couldn't find anything unusual about her behaviour.

OT: Oh, I see. Let's talk about Catherine. If you don't mind, I'm going to ask you some questions concerning her development so far to get an initial impression of her developmental status. You might also want to fill out this questionnaire for the next meeting. I'm going to observe Catherine for some time to get a picture of her playing as well as general skills. This might take a couple of weeks. If you have any questions, feel free to ask at any time. I'll try to explain everything to you. You can watch the therapy to gain your own impression, if you like. When we're done with our observations, I will explain my findings to you and suggest the next step in therapy. Is that all right with you?

Mother: Yes, of course it is. I want to help my child.

OT: Ok, then let's start with some questions about Catherine herself.
…

Try to continue the interview by using the client history interview structure listed above.

PT Exercise

Imagine working as a physiotherapist in an outpatient department of a hospital. Today your first treatment session involves a concerned mother and her six-year-old daughter who has Down's syndrome and a learning disability and was referred by her GP for pain in both feet and decreased balance. She attends a special needs primary school and used to be very much involved in the school programme, especially in the daily physical education programme. For the last three months, the daughter has gradually refused to take part in any of the sports or recreational activities offered. The mother is very upset and concerned about her daughter's condition. She made an appointment with their family GP and he diagnosed the child with altered biomechanics of both ankles. He prescribed painkillers and arranged a physiotherapy referral. For a start, you need to establish the child's previous level of activity and any key event that might have triggered the pain and decreased balance as well as the communication level of the child. Find a possible introduction to a narrative interview between a therapist and a mother for the purpose of taking a child's history. Find an interview partner and ask him or her about "his" or "her" child. Take notes on the information you get. For the interview the suggested introduction might be helpful or you can make up your own conversation.

PT: Good day, Mrs Kearney, hello – and you must be Ann. Nice to meet you both, my name is Lisa and I will be your physiotherapist. Have you ever had physiotherapy before, Ann?

Mother: Oh yes, quite a few times in the past, isn't that right, Ann? But that was when Ann was still a baby.

PT: So, would you two like to come in then? You can both take a seat over here, please. Now, what is the problem?

Mother: Well, it is obviously about Ann. It all started a few weeks ago when Ann started mentioning to me that she does not want to go to school anymore, but would rather stay at home. She would cry when I took her to school and she said that she had pain in her feet and found it very difficult to walk… I then had a word with her teacher and she told me that recently Ann stopped participating in any sports and recreational activity and that she preferred to stay on her own and away from the other kids. She used to be so very much into her dancing and running, you know, I don't know what happened! She does not really talk about her pain very much, you know. I always find out when it is too late already and Ann starts crying. She just won't tell you early enough that she's in pain.

PT: Okay, so what I am going to do later on today is to assess Ann's mobility level at present and the range of motion, power and coordination of her feet and legs.

I would like to ask you a few questions, though, first of all regarding Ann's development and the previous physio sessions that you mentioned earlier. I also would like to try and determine with you any key event that might have triggered her problem and maybe find out with both of you a way for Ann to express her pain and concerns.

Mother: That is brilliant, thanks very much.

PT: Right then, so let's ask Ann herself. Ann, can you tell me why you have stopped doing sport at school? Is it due to the pain in your feet?
…

Try to continue the interview keeping in mind the goals of the interview as stated above.

4

SLT Exercise

Speech and language therapists obtain the same basic information in the same general manner as occupational therapists and physiotherapists when compiling a client history. Of particular importance to speech and language therapy, however, is the acquisition of information about a client's past and/or present communication history. This may include information about the client's style of communication/social communication skills, communication partners/environments and/or quantity of communication.

Imagine that you are contracted to work for the local secondary school. You've just started the school year and observed an English class at the request of the teacher. You were asked to observe Jason, one of the students sitting in the last row. When asked to read aloud in class, Jason immediately turned red in the face. He stammered at the start of reading the first word and as he continued to read it became apparent that his speech was not consistently fluent. It was clear that Jason had a fluency disorder.
You have arranged a meeting with Jason outside of class. In addition to further observing Jason's speech behaviours, you will also explore his psychological well-being, including his self-esteem, social interactions and school performance.

SLT: Hiya, Jason. Really glad you dropped by my office today. My name is Lucy Wray, I'm the school's speech and language therapist. Have you ever seen an SLT before?

Jason: Yeah, it's nothing new to me.

SLT: Uhuh. Can you tell me why you might have seen one in the past?

Jason: 'Cause I st-st-st-stutter sometimes.

SLT: Maybe we could talk further about what it is you learned from him or her in the past, if you found it helpful and if you're interested in having someone help you with your speech again.

Jason: Yeah, suppose so.

SLT: I also would like to ask you some more personal questions and have you fill out a questionnaire, time permitting, on how you feel about yourself. Shall we get started then?

Jason: Okay.
…

Try to continue the interview keeping in mind the goals of the interview as stated above.

Exercise

Develop your own specific client case from any field of OT, PT or SLT with a partner and sketch out the most important details. Then practise going through the appropriate initial assessment interview, one of you taking the client's role and the other the therapist's.

4.6 Documentation I – Case Notes and Diagnostic Report

Additional info online

Quality treatment in all areas of the health care system is not only desired but costs money. Medical doctors who prescribe treatment and the insurance companies that finance therapies are interested in evidence-based services. This requires procedures of precise documentation. Documentation is any entry into the client record that identifies the care/service provided, re-examination, or summation of care. It can appear in the form of case notes, diagnostic, assessment or evaluation reports, progress reports, or reports of opinion.

Documentation reflects a therapist's competence. Therapists have an important responsibility in describing evaluative findings, goals, intervention approaches, client progress and discharge plans (including family training and education). Collaboration with other health professionals and external case managers, such as third-party payers, is important in determining the medical necessity of intervention or the need to reauthorize a treatment modality. A client's documentation can also be seen as a legal record of a therapist's clinical reasoning, i.e. his or her professional knowledge and judgement. There are times when therapeutic documentation is used as evidence in legal proceedings. Considering client outcomes and the consistency with expectations for progress, documentation can be seen as an important aspect of programme quality improvement as well.

According to the American Physical Therapy Association Guidelines for Physical Therapy Documentation (1997), for example, **elements of documentation** include:

1. obtaining a history and identifying risk factors;
2. selecting and administering tests and measures to determine patient status in a number of areas;
3. evaluation (a dynamic process in which the physical therapist makes clinical judgements based on data gathered during the examination);
4. diagnosis (a label encompassing a cluster of signs and symptoms, syndromes, or categories that reflect the information obtained from the examination);
5. goals;

6. intervention plan or recommendation requirements;
7. authentication and appropriate designation of physical therapist.

Case notes are an informal method of quickly documenting or "noting down" client information. Case notes are often taken during the case history, initial interview, assessment and/or treatment sessions. They serve the purpose of being useful, quick references or reminders for the treating therapist regarding relevant medical information, test scores, client performance and therapy goals. Information from the case notes is eventually compiled into some type of formal report (e.g., assessment report, progress report, discharge report, etc.). In some settings case notes are referred to as "soft files".

Types of Documentation: Case Notes

Here is an example of case notes taken by a speech and language therapist:

Note

In all types of documentation abbreviations are used as a time-saving measure. In the **Appendix** you will find an abbreviation list including the abbreviations used in this unit.

SLT Case Notes

- ETT: duration ~ 2 weeks. Self-extubated Nov 20. No trach
- resonance: ok
- DOB: Feb 21st, 1965
- right facial weakness; right facial droop
- followed 3 step commands
- Dx: ICB, Grade III, secondary to PICA aneurysm
- pt is a lawyer; has own, very successful law firm
- date of admission to Hamilton General Hospital: Nov 6th, 2005
- ICU: Nov 7th to Nov 21st
- didn't know that she was ill
- Ms Dorothy Cummings
- surgeries: Crani and aneurysm clipping Nov 7th, 2008; Re-opening of crani and re-clipping Nov 9th
- chest – x-ray: Nov 20th RLL infiltrate
- off-topic during conversation; poor attention span
- Meds (relevant to swallowing): Domperidone, Losec
- Lives alone. Boyfriend. No kids.
- voice: breathy, probably dry, low volume
- pt's hobbies: equestrian, rock climbing, reading, dinner parties
- awake; O x 1
- speech: reduced artic. – bilabials in particular; slow rate – check further
- pt typically "perfectionist" → would not want to be "disabled"
- swallowing: oral spillage; reduced bolus transport; oral residue; delayed swallow; laryngeal elevation okay; though coughing with large sips liquids
- pt very social → "chatter-box"
- NPO → NG
- naming for common objects good, but didn't know what a stethoscope was

SLT Exercise

Organize the case notes in the appropriate categories listed below. Then decide the likely source of where the information came from: medical chart/ records, initial SLT assessment, initial assessment interview with patient, interview with caregivers/family.

Medical Information	Cognitive/Language
Demographic Information	Speech/Voice/Resonance
Social	Relevant Medications

Note

Demographic information refers to the factual, personal information about a person (name, age, date of birth, etc). Sometimes "social" information (e.g., single status) falls under both demographic and social categories.

Additional OT and PT Exercise

Make a list of information that is missing in these case notes but would be necessary to have in order to make an OT or PT recommendation.

Exercise

Write appropriate case notes based on the case histories you developed in Unit 4.5 (Initial Assessment Interview). You may add information from other sources as well.

Types of Documentation: Diagnostic Report

Here ia an example of a diagnostic report written by an occupational therapist.

Marc is a 26 year old real estate agent. He is married and has a 4-month old daughter. Marc was referred to occupational therapy by an orthopaedic surgeon with a medical diagnosis of de Quervain's tenosynovitis (inflammation of tendon sheaths on the abductor pollicis longus and extensor pollicis brevis muscles). He has constant wrist and thumb pain in his right dominant hand, which is a huge problem for him, since he uses a mobile for all of his e-mail correspondence, instant messaging and phoning.
Canadian Occupational Performance Measure (COPM):
Marc has difficulties typing and speaking on his mobile due to sharp stabbing pain in his thumb and wrist.
He cannot hold his daughter or help his wife with household chores due to pain.
Marc is frightened that he might lose sales because he is not returning messages as quickly as he used to. He can no longer chat for very long on the phone with his customers either.
His goal: "…to get rid of this pain and get back to work."
Evaluation of body function:

- Phalen's test (holding wrists in full flexion up to 1 minute): negative (positive = increased symptoms)
- Finkelstein's test (fully flexing thumb to palm while simultaneously deviating the wrist ulnarly): positive (= sharp pain)
- palpation over the first dorsal compartment: significant pain (8 on a 10-point scale)
- Tinel's sign (tapping over the nerve with fingers at wrist or medial elbow to determine presence of nerve pathology): negative
- no significant swelling or range-of-motion limitations
- significant pain with thumb flexion, extension and abduction

OT Exercise

Read through the following diagnostic report and write your own "case notes" in outline, i.e. abbreviated form. Formulate any recommendations you would make for further intervention.

4.7 Completing a Physical Examination

During the physical examination the therapist gives a series of polite instructions to the client.

As long, complicated explanations make it more difficult for the client to understand what he or she is asked to do, instructions are preferably phrased in a clear and concise manner. On the one hand, they may be given rather straightforwardly by using the imperative. On the other hand, the question form is also common in this situation as a way of collaborating with the client: *Could you please…? Would you…? Can you…, please?* Furthermore, adverbial expressions like "just" and "for a second" tend to soften the strength of the instruction and reduce the potential embarrassment of the situation.

Orders and Requests

Examples: instructions phrased as orders

- Try to touch the floor with your hands.
- Say "puh"-"tuh"-"kuh" as fast and as clearly as you can.
- Please hold out your arms for a second.
- Stick out your tongue, please.

Note

This form of instruction sounds more polite if you add "please" to your sentence.

Examples : instructions phrased as questions

Often **can** and **could** is used to ask people to do things:

- Can you move your tongue quickly from the left to the right and back again?
- Could you just hop onto the plinth for a moment?

Can is also used to ask if people are able to do something:

- Can you purse your lips?

Would is also used to ask people to do things:

- Would you lie flat on the plinth for a moment?
- Would you open your mouth wide?

I would like you to or **I would appreciate it if** are polite ways of saying what you want:

- I'd like you to keep your knees straight.
- I'd appreciate it if you would just take a seat on the plinth.

Note

In the Appendix you will find more examples of instructions.

Exercise: Giving instructions

Additional info online

Here is an example of a physiotherapist's instruction for the physical examination (back assessment). The verbs in the table below are missing from the text. Please fill in the gaps. Some verbs may be used more than once. Remember to use the appropriate verb forms, e.g. *–ing* form.

bend	bring	change	come	cross
feel	give	have a look	hold	hollow
keep	lean	lie	lift	maintain
place	pull	push	put	remain
roll	sit	slide	stand	stay
take	touch	turn	twist	

Okay, would you like to _____ (1) off your trousers and _____ (2) the shorts on, please?

Would you mind _____ (3) your shirt off please, so that I can _____ (4) at your back and shoulders?

Okay, just _____ (5) there nice and tall and facing the wall.

Can you _____ (6) me touching your lower back here? Any pain?

Right then, can you please _____ (7) forwards as much as you can? Try and _____ (8) your toes with your fingertips.

That's fine, now _____ back up very slowly _____ (9).

Now, _____ (10) your arms at your side, can you slowly _____ (11) down your right side with your right arm? Don't _____ (12), please. Now, the same thing to the left, please, sliding your left arm down your left side. Any pain?

Would you please _____ (13) your arms in front of you and _____ (14) your left hand onto your right shoulder and your right hand onto your left shoulder.

That's great, now _____ (15) up your elbows. Good.

Try and _____ (16) your shoulders over to the left as much as you can – do not _____ (17) your hips as well, they _____ (18) the way they are, your hip bones remain _____ (19) straight ahead.

The same movement turning to the right now, please.

Okay, now try and _____ (20) backwards as much as possible.

Right, I will _____ (21) my hand here onto your hips. Try and _____ (22) on your left leg only. That's it, now try and _____ (23) your right knee towards your chest – no, don't _____ (24) your upper body, just _____ (25) the knee towards the ceiling. Brilliant!

_____ (26) on your right leg now – you can _____ (27) onto the back of this chair if you like to _____ (28) your balance. Do not _____ (29) on the chair.

Now, would you please _____ (30) your left knee up towards the ceiling… that's it, thanks.

I just want to have a quick look at the movement in your legs now, would you mind _____ (31) down on your back on this plinth, please?

Can you _____ (32) your right leg off the plinth and _____ (33) your right knee up towards your chest, please? Good, and the left leg … Good.

Can you _____ (34) your right leg up again so that your hips and knees are bent at right angles. Okay, now _____ (35) your leg in this position. I will _____ (36) you a little bit of resistance here on the outside of your knee. _____ (37) at my hand and do not let me _____ (38) you away – _____ (39) it there, _____ (40) it. Fine, now _____ (41) directions, I will _____ (42) my hand here on the inside of your knee. Try and _____ (43) your knee into my hand as much as you can now, that's it, don't let go. Great, well done.

Now if you don't mind would you please _____ (44) onto your left side? Brilliant, now _____ (45) on your left side with your hips bent and pelvis

and shoulders square. Very good, can you _____ (46) your stomach? Great! _____ (47) you heels together. Good. Now try to slowly _____ (48) your right knee up towards the ceiling. Make sure your hips and shoulders stay stable and don't move forwards or backwards. That's excellent, can you do the same _____ (49) on your right side now? Just _____ (50) over onto your right side, please.

Finally, could you please _____ (51) onto your stomach?

Fantastic, you can now _____ (52) at the edge of the bed again and we will discuss the findings.

Simulation Task

Find a partner, think of a particular type of physical examination and then practise giving instructions. Take turns being the therapist and the client. Remember to consult the section "Useful Phrases for Therapists" in the Appendix.

4.8 Clinical Reasoning Processes in Chest Physiotherapy – An Excursion to Respiratory Physiotherapy Treatment

Exercise

This is an example of a clinical reasoning process in respiratory/chest physiotherapy. Read through the text and follow and continue the reasoning process by answering questions 1 to 5. Can you find further possible answers as the ones given already?
You can compare your results with the answers given in the Appendix.

Case Study Chest Physiotherapy

"Chest Physio" requested on referral.
P/C: 32 year old woman, 14 wks pregnant, admitted with three day Hx of SOB, headache, white sputum and severe pleuritic pain and pyrexia *(= high temperature)*.
PMHx: DVT, 2 children
SHx: smokes 10 cigs/day x 12 yrs
Investigations ABGs:
pH 7.41 **pO_2** 7.52 **pCO_2** 3.45 **HCO_3** 18.6
CXR: nil performed
On examination:
The patient is anxious, SOB with RR 18 bpm, mouth breathing on 4l O_2 via NP, SpO_2 91%. Desaturating immediately on R/A. She is apically breathing with poor thoracic expansion. She is perched at edge of chair. O/A decreased air entry L base.

Questions

1. **What is the state of her ABGs on admission?**
2. **What would be your first line of action in the management of this patient?**

3. **What possible diagnosis could be present?**
4. **What additional information would be beneficial to determine diagnosis?**
5. **What treatment could we offer this patient in the various diagnoses?**

Information on ABGs

Arterial blood gases (ABGs) provide information on the ability of the lungs to work effectively, which means the delivery of O_2 to the blood system as well as taking CO_2 back from it. The interpretation of ABGs allows one to determine problems regarding the gas exchange and base disorders. It is also essential for the monitoring process of O_2 therapy.

Normal ABG values:

pH Norm	7.35 – 7.45	PO_2 Norm 11.3 – 14 kPa
	< 7.35 Acidosis	SpO_2 Norm 95 – 100 %
	> 7.45 Alkalosis	(indicates the combination of O_2 with haemoglobin in the blood)

Note

A machine that can measure the SpO_2 (O_2 saturation), and should be available on each ward is called "sats monitor". It is used by attaching a measuring electrode covered in rubber on one of the patient's fingers.

PCO_2 Norm 4.8 – 6 kPa	**HCO_3** Norm 22 – 26 mmol/L
(Respiratory System)	(Metabolic System)
Base Excess Norm	–2 – +2

The pH defines whether the acid-base balance of the blood is normal or turning acidic (pH decreased) or alkalytic (pH increased).

The two "puffer systems" of the body that help to maintain a normal pH are the lungs and the kidneys. Abnormal changes in either system will affect the blood pH levels and indicate the origin of the problem resulting in changed ABGs.

The PCO_2 level represents the lungs' control of carbonic acid, i.e. the **respiratory system**. The HCO_3 represents the control of the kidneys of bicarbonate, i.e. the **metabolic system**.

For example, if the pH is decreased and the PCO_2 increased with a normal HCO_3, this indicates a disturbance in the respiratory system (abnormal PCO_2) and an acidosis (pH decreased).

If the pH is increased with decreased PCO_2 and normal HCO_3, this again indicates a disturbance in the respiratory system (abnormal PCO_2) and an alkalosis (pH increased).

Note

In the case of a respiratory acidosis or alkalosis pH and PCO_2 move in opposite directions!

If the pH is decreased and the HCO_3 is decreased with a normal PCO_2, this indicates a problem in the metabolic system and an acidosis.

If pH and HCO_3 levels are both increased with a normal PCO_2, this indicates a problem in the metabolic system and an alkalosis.

Note

In the case of a metabolic acidosis or alkalosis, pH and HCO_3 move in the same directions!

Acid-Base Disturbances

	pH	PCO_2	HCO_3
Respiratory Acidosis	↓	↑	N
Respiratory Alkalosis	↑	↓	N
Metabolic Acidosis	↓	N	↓
Metabolic Alkalosis	↑	N	↑

Compensation mechanisms

The human body will always attempt to compensate changes in the blood system in order to aim for normal pH levels.

Not compensated: pH abnormal, either pCO_2 or HCO_3 abnormal
Partially compensated: pH, pCO_2 and HCO_3 abnormal
Fully compensated: pH normal, pCO_2 and HCO_3 abnormal

What is ACBT?

One Active Cycle of Breathing Techniques consisting of 5 stages:

1. breathing control followed by
2. deep breathing (3 or 4 deep breaths) followed by
3. breathing control followed by
4. huffing (1 or 2 huffs) followed by
5. breathing control

In the deep breathing part of the exercise, the emphasis is on breathing **in**. Breathing out is gentle and relaxed. This is known as "thoracic expansion".

In the huffing part of the exercise, the emphasis is on breathing **out**. The huff is one short and strong breath out and must be long enough to move mucus from the small airways.

Huffing followed by breathing control is known as the "forced expiration technique" or FET.

The sequence is repeated until the mucus is ready to be cleared.

A deep breath in, followed by a huff or cough will usually clear the mucus from the upper airways.

The exercise sequence is repeated until there is no more mucus.

4.9 Interpretation of Test Results and Observations

Exercise

The words listed below are missing from the text. Please fill in the gaps. Use the plural where appropriate. The first one has already been done for you as an example.

assumption	assessment	description	emotion
evaluation	interpretation	observation	~~perception~~

When interpreting test results and observations, therapists must realize that their own perceptions (1) have a large component of subjectivity (see Unit 4.11 – SOAP notes). Test results are often based on individual _____ (2), which can be accurately (objectively) described, but as soon as a therapist assumes, thinks, or believes to have seen or understood a behaviour, he or she is interpreting or hypothesizing. Describing a movement pattern, for instance, can be formulated objectively as in "Johnny walked down the stairs holding on to the railing with his right hand, taking one step at a time". Describing an _____ (3) or a perception (e.g., self-worth or sensory experiences) is an assumption, for example, "Johnny's eyes were wide open and he *seemed* fearful". The word *seemed* tells the reader that this statement is an _____ (4) of a behaviour or observation. Objective _____ (5) can be formulated using action verbs such as: walk, run, jump, bend, flex, stretch, laugh, scream, talk, etc. Interpretations or _____ (6) can be formulated using phrases such as: seems to, appears as if, looks like, reacted as if, could be, etc. These words indicate that the therapist is interpreting what he or she thinks is happening. It is important to keep objective observations and interpretations separate when documenting _____ (7) results. In order to document _____ (8) scores and observations appropriately, i.e. objectively, in a formal assessment or diagnostic report, make sure to use phrases like: It appears/ed that…, It seems/ed that…, Mr X reported that…., … as reported by Mrs Y., … consistent with…, …. would suggest that… and so. Also remember to use the vocabulary related to "grading" things, i.e., "mild", "moderate", "severe" or "average" "below average", "above average".

Exercise

Read through the following short description of a child at play at his first occupational therapy session. Which observations are assumptions, i.e. interpretations? What is observable and what can only be assumed? Reformulate these observations using interpretative language when appropriate. Discuss your formulations with a partner.

Johnny is a five-year-old, blond, blue-eyed boy, who has been diagnosed with a pervasive developmental disorder. He has come in for an initial sensorimotor play evaluation. He entered the therapy room very slowly and disoriented. He was sceptical and fearful. Johnny ran directly to the tent in the corner of the room, crawled in and tried to hide himself. He did not touch the stuffed animals and cushions that were in the tent and demonstrated tactile defensiveness. He sat on the floor with adducted hips, in abducted knee rotation and with poor trunk posture. His muscle tone is low and he has a poor body concept. Johnny has an astute visual perception and verbally described all the play equipment in the room and how one could play with them. He remained, however, in the tent the entire observation time (30 minutes) and did not want to try out any of the movement equipment that he had described. He was too unsure of himself and very happy when the therapy session was over. Johnny ran out to his mother, took her by the hand and said, "Johnny go home!"

Adult Language Test

The following pages give you the example of a hypothetical language test administered to an adult client with an acquired language disorder (e.g., aphasia). The **raw scores** for each **subtest** were calculated by adding together the correct number of responses. An overall raw score for each language area was determined by dividing the **total** raw score by the average number of subtests within a given language area. In order to determine **severity**, a **standard score** was calculated from the raw score. The use of standard scores allows us to compare the client's performance to the **normal** population (i.e., normalized data), which could not be done with the use of raw scores alone. **Percentile scores** are a means of determining how the client performs relative to others (e.g., a client with a percentile score of 80 means that he is better than 80 percent of cases and worse than 20 percent of cases).

ADULT LANGUAGE TEST

Patient Score Sheet

Patient Name: _____ Diagnosis: _____

Date of Examination: _____ Date of Birth: _____

Subtest	Raw Score	Standard Score	Percentile
Spontaneous Speech		3	11
Fluency	43		
Syntax	25		
Prosody	37		
Total	105/3 = 35		
Auditory Comprehension		6	65
Yes/No	85		
Word Discrimination	82		
Commands	65		
Complex Material	45		
Total	227/4 = 57		
Naming		4	25
Confrontation Naming	55		
Word Fluency	5		
Responsive Naming	75		
Total	135/3 = 45		
Repetition	65	5	50
Total	65		
Written Expression		3	10
Spelling to Dictation	55		
Written Confrontation Naming	49		
Sentences	23		
Narrative Writing	12		
Total	139/4 = 35		

Subtest	Raw Score	Standard Score	Percentile
Reading Comprehension		7	72
Symbol Recognition	92		
Word Recognition	91		
Word-Picture Matching	91		
Sentences	68		
Paragraphs	40		
Total	382/5 = 76		
Construction		8	72
Drawing	88		
Block Design	82		
Calculation	76		
Total	247/3 = 82		

Normalized Data – Standard Scores

Subtest	Normal	Mild	Moderate	Severe
Spontaneous Speech	9-10	6-8	2-5	0-1
Auditory Comprehension	10	7-9	3-6	0-2
Naming	9-10	6-8	2-5	0-1
Repetition	9-10	6-8	2-5	0-1
Written Expression	9-10	6-8	2-5	0-1
Reading Comprehension	10	7-9	3-6	0-2
Construction	10	8-9	3-7	0-2

Note

The use of standardized scores and percentiles are not the only **statistics** in formal tests. There are several other measurs (e.g., age-equivalent scores) used to compare and determine client performance, strengths and weaknesses, etc.

Exercise

Describe in your own words the above findings but do not report numbers. Write a short paragraph (3-5 lines). (For example, "It appears that the client has a mild deficit with naming. Her spontaneous speech, however is relatively stronger…", etc.).

Exercise

Look closely at a standardized test that you may have recently administered or that you are familiar with. List the measures/statistics used to score this test in English. Are they the same or different to the above?

4.10 Treatment and Treatment Plan

Treating a Client with a Swallowing Disorder

Have a look at the following example of a treatment situation in speech and language therapy:

Situation: Alex has been attending therapy for half a year as an outpatient. He is currently undergoing dysphagia therapy with sEMG biofeedback. Alex was first acquainted with the SLT (Louise) during his inpatient stay at a rehabilitation facility for spinal cord injured (SCI) patients. He has a PEG and is currently NPO with the exception of sips of water by mouth. Alex has just come into the SLT's office (via wheelchair). He is, as always, accompanied by his spouse (Margaret).

Louise: Hello, Alex. How are you doing today?

Alex: Okay … well, I am on the tired side today. I had OT this morning at home and then the nurse was in shortly after. We started my tube feeds late and it was a rush to get here. I'm not confident that my swallowing will be any good today.

Louise: Sorry to hear that you were feeling rushed to get here today. Hmmm… would you like to have a few minutes break before we get started, maybe 15-20 minutes, so you can catch your breath?

Alex: No that's okay. I think I'd like to get started now. This way we don't get home so late either.

Margaret: Alex, don't forget you wanted to tell Louise that you think the amount of saliva you had has decreased in the past few days.

Alex: Oh right. I noticed over the weekend that I have less saliva to spit out. That must be a sign that my swallowing is improving. What do you think?

Louise: Sure, that could be a reason. On the other hand have you had any changes in your medications or tube feeding schedule lately?

Alex: Yes, actually. Last week my physiatrist started me on Ditropan.

Louise: That could be an alternative reason why you are experiencing fewer secretions. Ditropan is known to have significant dry mouth side effects. Is your mouth or throat uncomfortably dry now?

Alex: No, not at all. Up until a few weeks ago I still had so much saliva. I like it now that I have to spit less frequently.

Louise: Okay, good. Did you take the opportunity to take some sips of water over the weekend when you felt thirsty?

Alex: Yes, but only small sips. I still cough if I take too large a sip.

Louise: Hmmm… Why don't we take a look at how things with your swallowing are today. First, some exercises to strengthen your swallowing muscles and then some swallowing practice with pudding. I just need a minute to set up the sEMG biofeedback programme. Do you mind using this alcohol swab to wipe your neck?

Alex: Not at all (takes wipe).

Louise: Thanks. And now I'll place the electrodes as usual.
(Set up complete).

Louise: Okay. Let's start with some Mendelsohn exercises. I would like you to complete ten in total. I'll review how this exercise is done with you again: first, swallow your saliva several times and pay attention to your Adam's apple. Notice how it lifts and lowers when you swallow. This time when you swallow and you feel your Adam's apple lift squeeze hard with your muscles and don't let it drop. Hold it for a few seconds.

Alex: *(attempts Mendelsohn)*. Oh, I'm not sure I did it right.

Louise: Actually, that was a good attempt. Try again and this time also pay attention to the computer screen. When you see the signal on the computer form the shape of a table, then you know that you have done it correctly.

Alex: *(attempts Mendelsohn again)*.

Louise: Oops, I see that you are squeezing with your muscles after your Adam's apple has dropped. The signal on the computer wasn't in the shape of a table. Try it again please, squeezing when your Adam's apple is up.

Alex: *(attempts Mendelsohn again)*.

Louise: Much better! You squeezed your muscles at the right moment. Try it again exactly as you just did.

Alex: *(attempts Mendelsohn)*.

Louise: Good again. And look, the signal was in the shape of a table. Okay, eight more times…
(Therapy continues)

Louise: Great session today, Alex! You've really got the hang of the Mendelsohn manoeuvre. Also, the number of swallows you completed was higher today than last week. Excellent work considering how tired you were when you arrived!

Alex: Glad to hear it. I am motivated to get it right. I want this problem to go away… Tomorrow we are on again at 2, right?

Louise: Yup. I have you scheduled for the full hour, from 2 until 3.

70 **Alex:** Okay then, see you tomorrow.

Louise: Enjoy the rest of your day. Bye!

Note

The Mendelsohn manoeuvre was initially described by Logemann and Kahrilas (1990) as a compensatory technique (i.e., to be applied with the ingestion of a food or liquid bolus). It is thought to assist with hyoid-laryngeal excursion and duration of upper oesophageal sphincter (UOS) opening during the act of swallowing. Evidence-based research has demonstrated that the Mendelsohn manoeuvre is safest and most effective when applied not as a compensatory technique (as described above) but rather as a rehabilitative tool. The physiology of the swallow act may be improved in select clients through repeated exercise. Clients are instructed to prolong or "hold" their pharyngeal swallow when the larynx is at the point of maximum elevation. The exercise is most often accompanied by surface electromyographic (sEMG) biofeedback.

Questions

Have another look at the dialogue:

1. **How does the therapist mark the sequence of instructions?**
2. **How does Louise explain the treatment to her patient?**
3. **How does she advise, encourage or caution Alex?**

Can you think of other ways of doing this? Write these down and then compare them with the list of phrases in the Appendix.

Simulation Task

Get together with a partner and think of a typical treatment session for a patient case. How do you structure the session? Start by thinking of possible ways of giving explanations or advice, instructions and feedback to the patient. (You may also refer to the list of useful phrases in the Appendix.) Then practise the conversation together, taking turns in being therapist and patient.

Types of Documentation: Treatment Plan

After assessing their clients, clinicians develop comprehensive treatment plans for them.

According to Hegde (2003) a comprehensive treatment plan may include:

1. a brief summary of previous assessment data
2. treatment targets
3. treatment and probe procedures
4. maintenance programme
5. follow-up and booster treatment procedures

Here is an example of a treatment plan from OT:

Greg is a 17-year-old boy with a diagnosis of nonverbal learning disorder (NLD).
He has a history of poor academic performance and is failing in maths and science. He often forgets to hand in assignments and "fades out" during instruction. Greg's behaviour is described as being defiant and non-compliant. He lies to his parents about his homework.
Intervention plan: one-on-one **direct treatment** plus **consultation** with school and parents

- a teacher in-service to promote understanding of NLD
- assisting Greg to set up an organizational binder, including an academic planner to use daily
- develop sensorimotor self-regulation strategies to increase greater alert attention throughout the day
- collaboration with the teacher to modify Greg's daily class schedule, allowing for harder classes, which require greater attention, to be scheduled at the beginning of the day
- increasing proprioceptive activities to support better posture, tone and endurance (daily swim programme and weight training using a therapy ball)
- holding monthly teacher conferences to assist with problems that come up in class and to improve therapist-parent-teacher communication
- holding parent meetings to promote a greater understanding of Greg's disability and developing a home programme of organizational support and school advocacy

Note

NLD is a neurological syndrome in which a person has difficulty interpreting and understanding nonverbal cues in the environment. The syndrome includes Asperger's syndrome (AS) and high functioning autism (HFA).

OT Exercise

Noah is a nine-year-old boy who has been participating in school-based occupational therapy sessions to improve his writing skills. Towards the end of the school year after a therapy session, his therapist wrote the following case notes:

Noah has developed average skills in penmanship during this school year. Today he demonstrated the ability to form all lower-case letters in cursive, but he still has difficulty connecting the cursive letters. Connections are sharp and pointy; letters are cramped together; 4 words out of 10 were illegible (see worksheet).
Capital letters in cursive – D, L, I, S, G are not yet possible. Noah visually perceives the curves but cannot draw them. He uses 2 lines forming a sharp point instead.
Noah expressed frustration and impatience over his unsuccessful attempts. He does not want to come to OT anymore.
Plan for the next session: 1) Establish client-centred goals with Noah for the coming school year, 2) Discuss new methods to try that are fun, e.g. cartoon drawing, 3) Develop home strategies to practise cursive writing over the summer with self-motivating activities, e.g. writing in the sand at the beach! Noah should make his own suggestions because he is very creative and has lots of ideas.
Write your own treatment plan for Noah. You may add additional information to the case study as needed.

Write your own treatment plan for Noah. You may add additional information to the case study as needed.

Get together with a partner to perform the next treatment session between Noah and his therapist.

PT Exercise

Graham is a 73-year-old gentleman who was admitted to hospital following an MI (myocardial infarct) four weeks ago. He was treated with blood thinning medication. He then developed a cerebral haemorrhage two weeks later and was diagnosed with a right-sided CVA and left-sided weakness. He also shows symptoms of moderate aphasia and drowsiness. At the end of the first physiotherapy assessment the physiotherapist took the following case notes:

11.30 a.m. Graham is sitting out in a buxton chair on arrival. He was hoisted out by the N/S at 8 a.m.
His vitals are stable, he is afeb. He has an IV antibiotics cannula in his left arm (elbow). It is noted that Graham still receives aspirin treatment for his heart, his INR is high.
On auscultation his breath sounds are reduced bibasally, no further added sounds. He sits in a slumped position (= kyphotic and flexed trunk and shoulders). He is able to look at me and focus and respond to simple commands. His position in the chair is rotated over to the left affected side, he avoids looking over to his right good side. His right leg is hyperactive and flexed.
The ROM of the right UL and LL is normal and he can actively move his right arm and leg. The tone in his right hamstrings is increased.
He presents with low tone in his left UL and LL and has no active movement at all. His left hand is swollen. He reports severe pain when his left hand, elbow, shoulder and knee are moved passively. He tries to resist the movement with his good side. His left shoulder is subluxed.
During the assessment Graham keeps nodding off. He wakes up again when addressed loudly.

Note

INR international normalized ratio, if INR is high = bleeding can occur, if INR is low = clotting can occur. Normal INR = 1.0.

Read through the notes again and imagine you were to take over Graham's case as a new physiotherapist. Please write a treatment plan for his next session with four to five main aspects that you think physiotherapy should concentrate on. What should you suggest to the nursing and medical staff to improve Graham's treatment and care?

Write your own treatment plan for Graham. You may add additional information as needed.

Get together with a partner to perform the next treatment session between Graham and his therapist.

SLT Exercise

Tony is 65 years of age with a moderate motor aphasia and moderate to severe apraxia of speech. He uses a detailed communication book, drawing and some writing to facilitate communication. Tony has just started to attend an aphasia AAC (alternative and augmentative communication) therapy group once a week offered by the outpatient SLT department at his community hospital. At the end of his second visit the SLT facilitating the group wrote these case notes:

Tony's attention and ability to maintain the topic of conversation appear to be very good and he demonstrates good turn-taking skills.
At the onset of group, Tony makes several attempts to respond to questions and otherwise participate in the group discussion, however, he continues to use speech as his primary mode of communication and is not well understood by other group members.
After several unsuccessful attempts at getting his message across, Tony becomes "quiet" and otherwise no longer participates in group.
Plan for next session: 1. Encourage/remind Tony to use AAC devices/strategies throughout group session – have other group members do this as well. 2. Provide positive feedback when Tony has successfully used AAC device/strategy to promote continued use. 3. Plan to meet with Tony either ½ hour before or ½ hour after next group session to discuss with him frequency and ease of use of AAC devices/strategies outside of group therapy (i.e., at home, bank, grocery store, family gatherings, etc.). Inquire about quantity of vocabulary and phrases (i.e., too much, too little?), access (i.e., to pages in communication book – can he easily find the words/phrases/pictures that he needs?), comfort with use of devices/strategies, etc.

Write your own treatment plan for Tony. You may add additional information to the case study as needed.

Get together with a partner to perform the next treatment session between Tony and his therapist.

4.11 Documentation II – SOAP Notes

Additional info online

In English-speaking countries health professionals often follow a standardized form to take their assessments called SOAP. In multi-professional teams this format facilitates communication among team members (doctors, nurses, therapists, dieticians, etc.) who are involved in the treatment of the same client. In this case the notes are written down during the assessment and treatment phase immediately after working with a client.

S stands for **subjective**, under which the therapist records the personal opinion of his or her patients such as how they feel, any emotional aspects or pain patterns, anything personal the patient would like to tell his or her therapist.

O stands for **objective**, which summarizes the therapist's objective assessment such as ROM measurements, power and swelling of joints, colour of skin and skin condition in general as well as possible joint deformities, muscle wasting, grip strength, coginitive abilities and any other special therapeutic tests. ROM, strength and symmetry findings of an oral-motor examination, acoustic results of a voice assessment, a vocabulary inventory from a language sample, a standard score on a formal language battery, pass/fail on a hearing screening, and findings from a VFFS (videofluoroscopic swallow study) are all examples of objective findings in a speech and language therapy assessment.

A stands for the therapist's **assessment** (or **analysis**) of collected data and his or her reflection on possible causes and natures of the presenting problems. In other words, it's a reflective synthesis of the information including conclusions and recommendations.

Finally, under **P** the therapist sets up an individual treatment **plan**, which is discussed with the patient. Every therapist must respond to the ethical principles of his or her profession such as respect for the individual, informed consent and confidentiality. A treatment plan is formulated with the patient (European Core Standards of Physiotherapy Practice 2002).

Any note can be written in the SOAP format, e.g. an initial assessment, a discharge report, a daily note, a progress report, etc.

Note

Some recording systems used in therapy departments have sections which are "written" only in the sense that a pen is used. In these busy days, writing words is time consuming and you may find yourself confronted by a mixture of symbols, charts, scales, abbreviations and "tick lists". Systems rarely rely entirely on symbols such as these, however, for while they may save time, they also select and shape information in ways which may be detrimental to patients (French & Sim, 1993, p. 52).

Discussion

Have a look at the following statement by French & Sim (1993, p. 57f.):

"[…] the division between 'objective' and 'subjective' which is at the heart of the system may encourage misconceptions. There is a danger that the therapist's findings may be given undue priority over the patient's own views. 'Objective' clinical tests and measurements are not necessarily free from subjective influences, and what the patient has to say about his or her 'subjective' symptoms may be based on highly objective evidence."

What is your opinion: Are objectivity and subjectivity "troublesome concepts"? Give reasons in support of your answer.

Assessment sheets

Please note that the assessment sheets on the following pages are general examples and spacings between the categories are not definite. That is, summaries written for each subcategory may actually vary in length and require more space than given in these exemplary forms.

PT Exercise

Think of a patient case with a peripheral complaint (e.g., upper limb or lower limb problem such as a fracture) and fill out the assessment sheet on page 124 or create your own SOAP assessment. Try to use the abbreviations given in the Appendix.

SLT Exercise

Think of a patient with a language disorder (adult or child) and fill out the assessment sheet on pages 125–126 or create your own SOAP assessment based on your supposed findings.

Types of Documentation: PT Initial Peripheral Joint Assessment in SOAP Format

Name: _____ Date: _____

DOB: _____ Therapist: _____

Occupation: _____

Hobbies: _____

Relevant History:

Dx: _____

Hx of Injury: _____

PMHx: _____

FHx (if necessary) _____ SHx: _____

SUBJECTIVE

Present Symptoms _____

_____

Present since: improving – unchanging – worsening

_____

Aggravating Factors: _____

Easing Factors: _____

Disturbed Night Sleep: _____

OBJECTIVE:

Joint ROM:

Joint Movement	ACTIVE right	ACTIVE left	PASSIVE	RESISTED

Comments and other relevant points:

Posture	Swelling	Colour	Deformity	Ms. Wasting

Special Tests:

Accessory Movement:

Palpation:

ANALYSIS: _____

_____

PLAN:

Short-Term Goals: _____ Treatment: _____

Long-Term Goals: _____ Treatment: _____

Signature: _____

Types of Documentation: SLT Initial Assessment Report in SOAP Format

DEMOGRAPHICS

Name: _____ Date: _____

DOB: _____ Therapist: _____

Occupation: _____

Hobbies: _____

BACKGROUND INFORMATION (or as above, Relevant History):

Dx: _____

Hx of Injury: _____

PMHx: _____

FHx (if necessary) _____ SHx: _____

DESCRIPTION OF THE PROBLEM *(Subjective)*
(also include here onset, duration & progression of symptoms)

_____

_____

CLINICAL OBSERVATIONS *(Subjective)*
(include here description of client's ability and willingness to be tested; responsiveness to testing and examiner; attention to test administration and test completion; description of difficult or unusual behaviours and what facilitated their management; evidence of self-correcting, self-cueing, insightfulness, judgement).

_____

_____

ASSESSMENT RESULTS *(Objective)*

Oral Mechanism Exam: _____

Labial Function

lip closure at rest: symmetrical +/– _____ droop _____ R/L _____
lip retraction: normal _____ reduced _____ R/L _____

Lingual Function

tongue protrusion: symmetrical +/– _____ range +/– ____
tongue retraction: normal _____ reduced _____
tongue elevation: normal _____ reduced _____
tongue strength: normal _____ reduced _____ R/L _____

Mandibular Function

mouth opening: symmetrical +/– _____
jaw lateralization: normal _____ reduced _____ R/L _____
strength of mandibular elevation: normal _____ reduced _____
strength of mandibular depression: normal _____ reduced _____

Velar Function

elevation: symmetrical +/– _____ reduced _____ R/L _____

▼

Reflexes
gag reflex +/– _____
cough reflex: strong weak absent

Voice
quality: normal breathy hoarse strained-strangled
loudness: normal reduced
pitch: normal reduced range

Resonance normal hypernasal hyponasal nasal emissions

Articulation normal abnormal

Spontaneous Language Sample (summary)

_____

_____

Expressive Language
(include tests administered & scores)

_____

_____

Receptive Language
(include tests administered & scores)

_____

_____

Audiological Screening

Frequency (Hertz)	Right Ear	Left Ear
250 Hz		
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		
8000 Hz		

SUMMARY and CONCLUSIONS *(Analysis)*:

_____

_____

RECOMMENDATIONS *(Plan)*:

Short-Term Goals: _____ Treatment: _____

Long-Term Goals: _____ Treatment: _____

Signature: _____

Types of Documentation: OT Initial Assessment Report in SOAP Format

The following example is for an occupational therapy initial assessment in an adult rehabilitation home health clinic. A client example is provided.

Mountain View Home Health Clinic

Department of Occupational Therapy

Initial Assessment Date: 06/11/2008

Client: Mrs Janet B **DOB:** 26/04/1944 **Gender:** Female

Reason for referral and relevant history:
Right CVA 3 weeks ago; spent 5 days in acute hospital and had 2 weeks inpatient rehab; received OT, PT and SLT

Referred to home health OT for continuing rehab needs in ADL, IADL and community re-entry

Family situation: Divorced, 2 adult daughters in town, sister close by

Living situation: First floor apartment accessible by lift from garage entrance

Work situation: retired primary school teacher

Occupational Performance Assessment:

(Interview and administration of COPM)

Self- Care: (COPM results)

Area	Performance	Satisfaction
Independence in bathing	2	5
Dressing UL	4	3
Dressing LL	4	3
Driving	1	1
Providing care for grandson	2	1
Cleaning house	3	3
Going out for lunch/bridge	4	2

Functional Mobility:
- ambulates with a quad cane
- uses wheelchair for long distances

Productivity:
- volunteer work at her church
- provided child care for 4-year-old grandson 2 days a week

Leisure:
- plays bridge, enjoys reading and cooking

Clinical Observations and Test Results:
(Test results and observations can be listed here in the following areas for example)
- ROM (upper and lower extremities):

- sensation (light touch, pain, temperature, proprioception, and stereognosis):

_____

_____

- balance (static and dynamic sitting and standing balance):

_____

_____

- cognitive and sensory system status:

_____

_____

Strengths/Resources of Client:
- alert, no signs of depression
- skilled at organizing
- is very social, well liked by friends and neighbours
- daughters live in town and visit frequently
- has good access to health care and community services

Limitations:
- neglects left side
- low endurance
- poor balance and fearful of falling
- limited functional mobility

Client Goals:
- bathing and dressing herself independently
- gaining balance and strength
- resuming playing bridge and reading
- identifying alternative means of transportation to church

OT Intervention Plan:

(Analysis of the present situation and recommendations, e.g. environmental modifications and adaptive strategies can be listed here, as well as appropriate therapeutic exercises and activities to reach the above listed client goals.)

_____

_____

_____

_____

Therapist: _____

(Signature)

OT Exercise

Think of a similar client case and fill out the assessment sheet or create your own SOAP assessment. You can also try to use the abbreviations given in the Appendix.

4.12 Documentation III – Progress Report and Discharge Summary

Additional info online

At the end of a treatment period the OT, PT or SLT will write a progress report if difficulties or questions arise during a treatment process or a discharge report when the patient's treatment is finished. In a hospital, for example, these reports will be attached in the patient's medical ward chart or therapy chart. Progress reports or discharge letters are usually addressed to the health care professional who referred the patient to therapy in the first place, like a GP, consultant, nurse, dietician or the AHP him- or herself.

Discharge or progress reports are based on the SOAP format, where the therapist will summarize the patient's statements or concerns – if any were given – **(S)**, outline the findings of his or her initial examination, the treatment given **(O)** and results **(A)** and present condition at the time of writing either the discharge or the progress report. This may include what he or she expects to happen next, for example, "patient is discharged from therapy" or asking for a second professional opinion on further patient management **(P)**.

Some General Tips Concerning the Writing Style of Clinical Reports

- Keep reports short but concise.
- Use professional language and avoid colloquialisms.
- Use correct spelling, grammar, and punctuation and write in complete sentences.
- In general, write reports in the past tense and not in the present tense.
- Try to avoid using the first person by using the third person or the passive (e.g., "The test was administered" rather than "I administered the test").
- Don't use abbreviations people outside your own profession are not familiar with.
- Present information chronologically.
- Distinguish between objective observations and findings and interpretations.
- List all data (e.g., test scores) before giving your own interpretation of them (cf. Unit 4.9).
- Don't introduce new information in the summary section of the report.

Types of Documentation: Discharge Letter

The following is a paediatric occupational therapy case report in discharge letter form for a child who had moved with his family to England from his country of birth, Germany. The health services and school authorities in England were collecting data concerning previous educational and therapeutic interventions that the child had received, so that they could make an appropriate placement in the new country of residence.

TO WHOM IT MAY CONCERN

RE: Occupational Therapy report concerning Robert A., born 11.07.2002

I am a paediatric occupational therapist in Germany and have treated Robert and counselled his family since he was six months old. Robert suffered from brain damage after a bout of pneumonia that his paediatrician did not discover early enough. This caused epileptic activity following his resuscitation. The result was a pervasive developmental disorder (PDD), diagnosed as autistic spectrum disorder with components of a sensory processing disorder, fine motor control disorder and a language development disorder. The sensory processing problems were manifested as tactile / vestibular / proprioceptive modulation difficulties. The development of Robert's body concept is delayed. It appears as though there are very few neural connections between his self-determined performance goals and his bodily responses. He demonstrates stereotype behaviour such as shaking objects, biting his fist and placing objects in his mouth. Robert seems to have good receptive language but his expressive language abilities have not yet developed. He is unable to express his needs using speech, although he is beginning to use pictograms to assist his communication. Robert needs assistance in all aspects of his activities of daily living (ADL), e.g. eating, dressing, personal hygiene. He has no intentional control of bowel movements or bladder and his sleep pattern is irregular. Robert is ambulatory and demonstrates typical skills in his gross motor development, but he requires adult supervision at all times. He has the ability to emotionally relate to the important people in his life. At times his eye contact is very intense and he obviously enjoys giving out hugs and kisses as his attention allows. He is a bundle of glowing vitality that makes him very lovable!

While he was at pre-school, I treated Robert in my private practice and/or in a family diagnostic and treatment counselling centre using a sensory integration approach. Robert demonstrates the ability to take in information from his environment mainly through touch, visual and auditory perceptual channels and through oral stimulation. Deep touch, spoons, sand, vibration, drums, metallic sounds and eating all have special meaning for him.

He has been in mainstream schooling since he began his education. The philosophy of the Education for All Programme (EAP) in Germany maintains that provisions should be made in the integrative education classes (a) to promote proactive learning using individual competences, (b) to promote cultural and community relevant learning, (c) to provide individual and differentiated learning possibilities, (d) to provide learning opportunities that use all of the senses, (e) to provide opportunities for social learning, (f) to promote networking possibilities between various extra-curricular activities, (g) to support and encourage the taking on of responsibility and independent learning and (h) to provide specially designed instruction to meet individual needs of all children. The government has had great difficulty, however, in putting this mainstream concept into practice. Robert's mother has been politically very active in support of mainstreaming in educational environments, setting up programmes and trying to get appropriate legislation to assist children with special needs. Both she and her husband are very cooperative but their experiences with integrative concepts in the German schools have been very frustrating for the whole family.

Robert has experienced extensive sensory integration-based occupational therapy, physiotherapy, speech therapy, dolphin-assisted therapy and music therapy over the years. I would recommend that sensory integrative occupational therapy and music therapy, along with an intensified assistive communication programme be provided for Robert during his educational experience in England. He demonstrates an extensive potential for further development.

I have grown to love Robert and his family and want to help them settle into a new programme and new life in England in any way I can. I would be very willing to provide any further information, if needed.

Thank you sincerely for your consideration and assistance.

With my very best wishes from Germany,

Magdalena Karcher, Occupational Therapist

Exercise

Take the above case and write the discharge letter in SOAP-form and/or choose a case out of your own practice experience and write a treatment plan, progress report or discharge letter.

Types of Documentation: Progress Report

Patient Name _____ Date _____

Address _____ To _____

Physio No _____

Chart No _____ Presenting Complaint: Adhesive Capsule Shoulder _____

PROGRESS REPORT

Dear Dr Morgan,

Thank you for referring Mr Alun Roberts for treatment.
So far he has attended physiotherapy sessions on twelve occasions – from 19 Sept 2005 to 12 Jan 2006.
At the initial examination he presented with the following symptoms:

- pain in both shoulders (VAS 8)
- positive painful arc R and L
- restriction ē all ADLs
- decreased ROM and power (g 4(-)) R and L shoulder
- pain on palpation of R anterior shd. joint medially of biceps tendon
- "clicking" sound on L shd. motion antero-medial shdr. joint

Treatment:

- active/assisted Exs
- stretching techniques
- manual techniques
- frictions
- hot pack and TENS
- HEP

At present he has:

- pain in his L shd. (VAS 2-3)
- positive painful arc L
- managing ADLs "9 out of 10"
- full ROM R and L
- power R and L shd. g 4(+)
- "clicking" sound as stated above remains

Mr Roberts reports that the bilateral shoulder pain has decreased since doing his HEP, but reoccurs with repetitive shoulder movements and is unpredictable.
I would appreciate your opinion on further management.
Should you require further information, please do not hesitate to contact me.

Yours sincerely,

Richard Stevenson, BSc PT, MCSP

Note

It is common to thank the referring medical team for the patient referral received.

Types of Documentation: Discharge Summary

Patient Name _____ Date _____

Address _____ To _____

Physio No _____

Chart No _____ Presenting Complaint: Pain Lower Limb

DISCHARGE LETTER

Dear Dr Hamilton,

Thank you for referring Ms Margaret Davies for treatment.
She attended physiotherapy on six occasions – from 5 Oct 2005 to 15 Dec 2005.
At the initial examination she presented with restricted ROM of both hips, weak hamstrings and glutes bilaterally Trendelenburg L hip, varus position R distal tibia, over-pronated feet, kyphotic T-spine and flattened L-spine ē generally decreased trunk flexibility.
Treatment:

- general postural awareness and education
- Exs to improve trunk ROM
- Exs to improve hip strength and ROM
- VMO regime
- proprioceptive Exs
- insoles size 6
- HEP

At the time of discharge she had full ROM and power (g 5) in both hips, improved foot static as well as improved posture and trunk flexibility. The L Trendelenburg is still noticeable on increased walking distance (1600 yrds).
She carries out her HEP on a daily basis and I have advised her to continue her stretching Xs for a further two weeks. I do not feel that any further physiotherapy intervention is indicated, as she denies having any problems and is satisfied with her progress so far. Her mother reports that she has noticed a great change in her daughter's gait pattern and overall posture.
If you have any further queries, please do not hesitate to contact me.

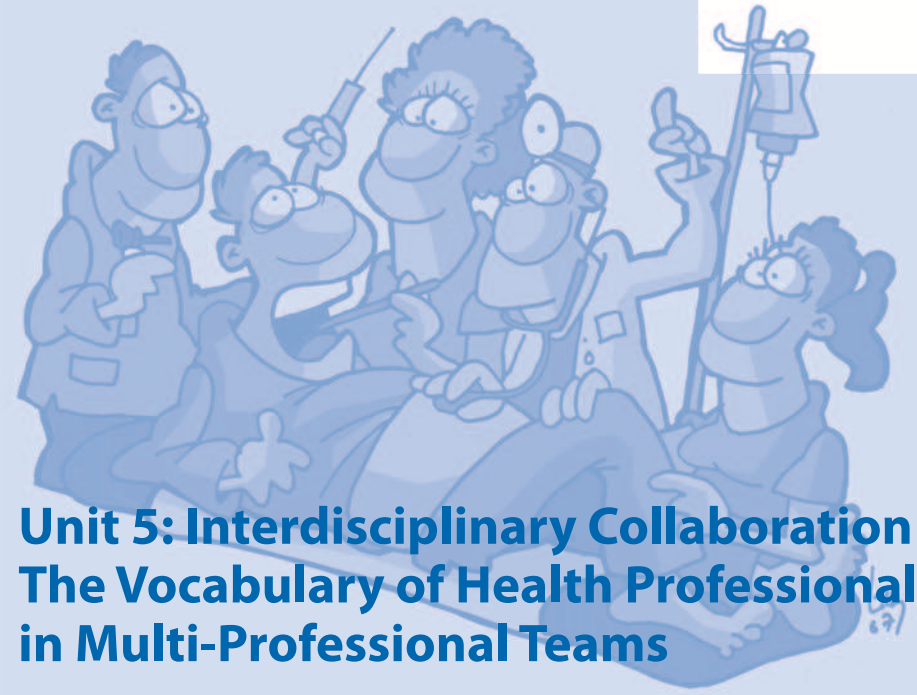
Yours sincerely,

Jenny Henderson, BSc PT, MCSP

Exercise

Create your own progress or discharge letter thinking back to a certain patient case in the past or using a fictional patient case. Try to keep it brief and use as many abbreviations as possible to outline your patient case. Follow the SOAP structure to write your report.

5



Unit 5: Interdisciplinary Collaboration – The Vocabulary of Health Professionals in Multi-Professional Teams

5.1 Health Care Teams and Team Collaboration

Working as a team in a health care setting has several benefits to health care, not only for the clients but also for the individual health professionals and the health care provider. Kouzes & Pozner (1987) define a **"team"** as "a group of equally important people collaborating, developing cooperative goals, and building trusting relationships to achieve shared goals". Good communication, decision-making and problem-solving skills, networking and brainstorming are the staples of a team that delivers good care efficiently.

The expression **"the sum is greater than the parts"** applies to health care teams as well as it does to other type of group work. Each team member contributes his or her expertise to the team and, in sum, the client as a whole person – that is, not just the medical diagnosis or disability in isolation – is considered. In this unit you will specifically learn more about the World Health Organization's (WHO) International Classification of Functioning, Disability and Health (ICF). The principles that underlie the ICF fit in nicely with the holistic approach to health care that teams provide.

The ICF is the WHO's framework for health and disability (WHO, 2002). It provides a model for the way that daily functioning and disability depend on and interact with **body function and structure**, a person's **activity** and his or her **participation** in society. Other contextual/environmental and personal factors may influence body function and structure, activity and participation and are also part of the ICF model.

The ICF has several uses at the individual (i.e., client), institutional and social levels. At the client level, for example, the ICF can be used to **drive treatment planning** (e.g., What treatments or intervention can maximize functioning? What intervention can be implemented that would maximize the client's participation in society?) or to **evaluate the outcomes** of said treatments or interventions (e.g., How useful was the intervention?). Furthermore, it helps **promote communication** between all members of the health care team at various points along the continuum of care. Working together, the health care team can generate solutions or strategies that maximize a client's function, activity and participation.

That said, teams generally meet on a regular basis to identify and set client goals or to discuss goal success and progress. In some facilities clients even actively take part in setting their own goals by attending **"goal-setting meetings"** with relevant team members. The actual structure, goal-setting and goal-attainment strategies that a team adopts depend very much on their philosophy and vary considerably from team to team. In general, teams function as one of three types: multidisciplinary, interdisciplinary or transdisciplinary.

In **multidisciplinary teams** assessment findings and goals are specific to the individual discipline. Team members achieve goals independent of each other and communicate either via direct or indirect means. The effectiveness of the team is the total sum of their individual efforts.

Interdisciplinary teams identify individual goals that are not duplicated or in conflict with another. Once the client's goals are established, each discipline works towards achieving said goals within the scope of his or her practice. When boundaries between involved disciplines overlap, team members collaborate and/or solve problems together.

In a **transdisciplinary team** one team member is the primary therapist or case manager. The other team members contribute to the client's care via the primary therapist/case manager. This approach requires that team members have a good understanding of and some training in the adjunct disciplines. In the transdisciplinary approach, one team member alone is thought to be able to meet client goals, regardless of his or her discipline. Alternatively, several team members may treat one patient, but role extension and overlap between the various health care professionals must still exist.

Today's health care facilities strive to provide **"client-centred" or "client-focused" care**. Here, a client's (note: "client" here can also include family or legal guardian) wants or wishes drive medical and rehabilitation goal choices. It is important to note that "client-centred" goals can be met regardless of team type.

Discussion

Draw on your experience of having been part of a health care team and answer the following questions:

1. **What "approach" did the team adopt?**
2. **How frequent were team meetings and for how long did the team meet? Did all members attend?**
3. **Were goals "client-centred"? Provide an example.**
4. **Did individual team members appear to have a good understanding of each other's roles and contributions?**
5. **What did your team do well? What might have been improved?**

Exercise

1. **Have you ever attended a "team building" seminar or event? If yes, did you find it useful? Describe details of your experience in a short essay (ca. 350 words). Alternatively have a discussion about this topic with your fellow students.**
2. **What opportunities have you had to learn more about the other health-related professions in your current educational programme? Write a short essay (ca. 350 words) or discuss this topic in your seminar.**

5.2 The International Classification of Functioning, Disability and Health (ICF)

The World Health Organization (WHO) has developed a new version of the International Classification of Disease – ICD-10. The new classification is called: International Classification of Functioning, Disability and Health (ICF). In comparison to the ICD-10, a major change in the language can be

observed that is used in the ICF. This new vocabulary has the potential of creating a **new communicative basis for all health professionals**, which may enhance the further development of interdisciplinary collaboration.

The ICF uses **client-oriented**, **resource-oriented** and **contextual** formulations, for example, "classification of disease" is now "classification of functioning". The contextual factors of a client's health condition are taken into consideration in more detail.

Disability and functioning are seen in the ICF as resulting from an interaction between health conditions, e.g. disease, disorder, injury and contextual factors.

Components of contextual factors:

- external – environmental factors, i.e. social attitudes, architectural environment, legal and societal structures, climate, etc.
- internal – personal factors, i.e. gender, age, attributes, social class, educational level, profession, present and past experiences, general behavioural patterns, adaptability, character and other factors that can influence how a disability is experienced by an individual

Human functioning can be described at three levels:

- at the level of the body or individual body parts
- at the level of body systems functioning as a whole, i.e. physiologically and psychologically
- at the level of social context

Impairments of body structure or function represent deviations from certain generally accepted population standards and can be temporary or permanent; progressive, regressive or static; intermittent or continuous.
A **disability** can include dysfunctions on one or more levels:

- activity limitations
- participation restrictions

Definitions of **ICF components** in the context of health:

- body functions = physiological functions of body systems (including psychological functions)
- body structures = anatomical parts of the body such as organs, limbs and their components
- impairments = problems in body function or structure such as significant deviation or loss
- activity = execution of a task or action by an individual
- participation = involvement in a life situation
- activity limitations = difficulties an individual may have in executing activities
- participation restrictions = problems an individual may experience in involvement in life situations
- environmental factors = physical, social and attitudinal factors in the environment in which people live and conduct their lives

Active Vocabulary: International Classification of Functioning, Disability and Health (ICF)

Additional info online

The English equivalents to the following words can be found in the above text. What are they?

- Aktivität, Handlung = _____
- Behinderung = _____
- Funktion = _____
- Gesundheitsumstände = _____
- Handlungseinschränkung = _____
- Kontextfaktor = _____
- Körperfunktionen = _____
- Körperstrukturen = _____
- Partizipation, Mitwirkung = _____
- persönlicher Faktor = _____
- Schädigung, Funktionsstörung = _____
- Teilnahmebeschränkung = _____
- Umweltfaktor = _____

Discussion

The ICF relates health and wellness to engagement in daily activities and ability to participate in society. Get together with students of other health professions (forming an interdisciplinary team) and discuss the following two points:

1. **How can each of the three professions (OT, PT, SLT) relate to the above statement, i.e. what role does engagement and participation play in the respective treatment modalities?**
2. **Can language really make that much difference? Classifying "function" instead of "disease" – a definite plus for client care?**

5.3 Health Professionals and Attitudes toward Disability

Defining a Disability

Health professionals within the medical environment have great influence on how disability is defined. Written documentation is a critical and necessary aspect of our jobs, and it takes many forms, such as chart writing, messages to colleagues, insurance claims, case study reports, incident reports, research analysis, and published articles. Along with the daily expectations of written documentation, health professionals talk with many different people in numerous formal and informal conversations. These people may include colleagues, clients, and their significant others, insurance companies, students, and paraprofessional staff. The actual words used in this correspondence create an image of the described person.

Health professionals should consistently use respectful language in all daily communication to promote a positive impression of their clients.

Summary

The formulation of a person's attitudes and beliefs regarding disability is contingent on various influential sources. Some of these factors are external sources that we learn from our environment, such as society's use of language, the media's stereotyped images of persons with disabilities, or the theoretical bases that constitute medical treatment and rehabilitation. Other sources are internal and assimilated into our belief system, such as our values about humankind and health, and our tolerance to differences.

Rehabilitation is an interactive process in which both the client and health care professional constantly influence each other in the therapeutic relationship. Each of us has unique perceptions about wellness and illness, normal and abnormal behaviours, and what constitutes a positive and negative body image. Our emotional reactions and anxieties about our own well-being can easily be projected onto others if we do not recognize and identify their existence within ourselves. Common expressions of sympathy and pity are efforts to alleviate our own discomfort when viewing a person with a disability. Often, our perceptions about this person are inaccurate and our attitudes are based on previously learned images or prior experiences. Concerned health professionals always directly check out their perceptions with those of their clients rather than forming assumptions based on external or internal influences. Health care workers know that faulty beliefs and stereotypes reinforce the development of negative attitudes toward persons with disabilities, and they make direct efforts to change these attitudes into positive ones.

An effective health professional is concerned about the person first and how rehabilitation and treatment could be collaboratively arranged for the client. With the knowledge of various treatment models, the health professional provides unconditional positive regard and individualized care, always conscious to present a positive attitude within this process. The client's feelings are acknowledged in the form of empathy, not sympathy, with the intent to empower and assist the client to accept and adjust to one's disability.

Finally, health professionals recognize that they are role models for others within the medical community, as well as society in general. They are aware of the power of their language when describing persons with disabilities and subscribe to defining disability in a positive, humane manner. Effective health professionals are dedicated to personal reflection and change regarding their own attitudes, beliefs, and perceptions, which significantly affect the rehabilitation process. In essence, they demonstrate a commitment to clients that offers a non-judgemental and unconditional regard for the person, regardless of the disability.

Questions/Discussion

1. **How does Tufano (2000) state the responsibility of health professionals towards clients with disabilities?**
2. **Do you agree with her? Give examples from your own professional experience.**

5.4 Assistive Devices

Additional info online

Here are some useful terms related to the field of assistive devices. Have a look at the table below and match each term with the correct definition.

1. assistive technology (AT)	2. assistive devices (ADs)	3. augmentative and alternative communication (AAC) devices
4. prosthetic devices	5. protective devices	6. supportive devices

a) communication boards or electronic devices such as portable communication systems, etc. that increases a person's ability to communicate [__]

b) corsets, compression garments, serial casts, neck collars, etc. that protect weak or ineffective joints or muscles [__]

c) artificial substitutes used to replace missing body parts [__]

d) items or pieces of equipment used to increase or improve the functional capabilities of individuals with disabilities [__] *Note: Technical aid is a similar/related term.*

e) braces, protective taping, cushions, helmets, etc. that protect weak or ineffective joints or muscles [__]

f) walkers, wheelchairs, crutches, canes, long-handled reachers, splints and other implements or types of equipment used to aid patients in performing tasks or movements [__]

Exercise

The pictures above show some assistive devices used by OT, PT or SLT clients. Decide which picture represents which type of equipment. The first example has already been done for you.

1. bathtub bench e	2. elbow crutches	3. hoist
4. knee brace (orthosis)	5. long-handled reacher	6. monkey pole
7. prosthesis	8. rollator	9. shower commode
10. shower seat	11. standing table	12. toilet safety frame
13. walking stick *or* cane	14. wheelchair	15. zimmer frame

1. arm sling	2. buttonhook	3. cochlear implant
4. communication board	5. custom-grip cutlery	6. dressing stick
7. electrolarynx	8. environmental control unit (ECU)	9. mouthstick
10. picture communication book	11. plate guard	12. safety grab bars
13. shoehorn	14. speaking valve	15. splint
16. spork	17. voice output communication aid (VOCA)	18. voice amplifier

Exercise

Plan a treatment session of your own choice and write a brief text involving materials you will use during this treatment and what you think you will achieve by using these materials. You will find lists of occupational therapy, physiotherapy and speech and lan guage therapy equipment in the Appendix.

5.5 Areas Covered in Rehabilitation Programmes

The following areas are typically covered in rehabilitation programmes.

Decide which activities from the list below are commonly performed in the individual areas. One has already been done for you as an example.

AAC	addressing attitude problems	addressing behavioural issues	alternative methods of managing pain
assistance with adaptation to lifestyle changes	bathing	breathing treatment	~~concentration~~
dealing with emotional issues	discharge planning	dressing	education about the medical condition
exercises to promote lung function	feeding	grooming	guidance with adaptive techniques
information on medical care	medication	memory	nutrition
pain medication	problem-solving abilities	skin care	social interaction at home
social interaction in the community	speech	support with financial issues	toileting
transfers	ventilator care	walking	wheelchair use
work-related skills	writing		

a) cognitive skills	– concentration – _____ – _____
b) communication skills	– _____ – _____ – _____
c) education	– _____ – _____ – _____
d) family support	– _____ – _____ – _____
e) mobility skills	– _____ – _____ – _____
f) pain management	– _____ – _____
g) physical care	– _____ – _____ – _____
h) psychological counselling	– _____ – _____ – _____
i) respiratory care	– _____ – _____ – _____
j) self-care skills/ADLs	– _____ – _____ – _____ – _____ – _____
k) socialization skills	– _____ – _____
l) vocational training	– _____

Exercise/Discussion

1. **Which professionals are involved in providing services in these areas? Draw on your own experience and refer back to** ► Units 3.1 **and** 3.2**.**
2. **In which areas or activities is a multi-professional team approach common?**
3. **Do some research to compare the experience in your own country with that in others.**

5.6 Team Conference on an Inpatient Sub-Acute Stroke Unit

In the current practice of evidence-based medicine, it is more and more common to see the conglomeration of all specialized medical and therapy services for stroke patients on one unit or ward of acute and early rehabilitation hospitals. In such settings the "stroke team" eventually arranges a time to meet together with the patient (if possible) and his or her family (and/or caregiver and/or substitute decision-maker). This meeting time or "team conference" is a platform whereby all parties involved can give and gather information, including patient wishes, progress to date and discharge options.

The following is a case example of a team conference for Mrs Downey, a 45-year-old mother of two young children (ages 9 & 5), who experienced a large left middle cerebral artery infarct three months prior. She has been on the early rehabilitation stroke unit for a total of three weeks. The team in attendance includes the social worker (SW), attending physician (AP), primary care nurse (PCN), occupational therapist (OT), physiotherapist (PT), speech and language therapist (SLT) and home care representative (HCR). The patient (Mrs D.) is accompanied by her spouse (Mr D.) and her sister (Ms M.). The social worker opens the meeting and provides an overview of what is to be expected in it.

SW: Good afternoon, Mrs Downey, Mr Downey, Ms Martin. We are really pleased that you could meet with us today. As you already know I'm Suzy Jamal, the social worker on this unit. We thought it was a good time for us to meet and provide you (looking at Mrs D.) and your family with an update of your progress since your stroke. We would also like to discuss with you your options for further rehabilitation after you are done here at our hospital. Just before we get started, why don't we have a round of introductions?

(Team begins round of introductions)

AP: Hi, I'm Dr Wong, you already know me well. I'm afraid I'll have to excuse myself a little earlier from this meeting today.

OT: I'm Margaret, I'm the occupational therapist.

HCR: I'm Barb, the home care representative.

SLT: My name's Maurice, I'm the speech and language therapist.

(Etc.)

SW: I think we'll start by having each of the members give you an individual update on his or her area of expertise. Would that be okay with you?

Mrs D.: *(nods)*

Mr D.: Fine.

AP: And I'll be the first given my tight schedule today. As you know, Mrs Downey, you suffered a rather large stroke on the left side of your brain.

We've been particularly careful to keep your blood pressure and diabetes under control since your admission. You did acquire a lung infection while here (aspiration pneumonia) and that was successfully treated with antibiotics. You were also MRSA positive for a while but as of yesterday your swabs came back negative which means that your therapists and family won't have to wear isolation gowns anymore when visiting or working with you. From a medical point of view you have been medically stable for some weeks now and we expect that you'll keep that way for a while yet. Do you have a good family physician?

Mr D.: Yes, actually we do. He's known us for about ten years now.

AP: Excellent. When it's time for you to go home it'll be your family doctor who will further manage your medications. In addition to that, a follow-up appointment with me in about six months' time would be good. Do you have any questions?

Mr D. & **Ms M.:** Nope, it's all clear so far.

AP: Okay then, I'd best be going now. (AP leaves)

SLT: My focus with you, Mrs Downey, was first to manage your swallowing. In sum you have a mild swallowing difficulty but you can manage a regular diet very well in my opinion. I think we are a bit concerned about your overall lack of intake, however, but I'll defer that part to Rachel, our dietician, and she'll speak more to you about your nutrition. As for your communication, you continue to demonstrate that your understanding is relatively good – yes, I see you nodding in agreement – but expressing yourself is much more difficult. Right now in therapy we are targeting sound production and giving reading/writing some attention as well. I think the reading/writing are going to be particularly important for you because they will serve as an alternative route for you to express yourself.

Ms M.: Do you think that my sister will talk normally again?

SLT: That's a good question. Because of the size of your sister's stroke and its location, I'm afraid speaking may pose difficult for her for some time yet. That's not to say that it won't improve at all. We certainly will give it a shot and do our best to help her along in her speech. In the meantime consider writing as a way to bridge the gap and give your sister a way to communicate, that is, get a message "out". As a point of clarification only, the difficulty that your sister encounters in speaking in no way reflects her intelligence. She certainly gives us reason to believe that her thinking skills are relatively intact. For example, Mrs Downey, you always remember what time your therapy session is, you recall what you learned from the previous session, you are aware of when you've made a speech error and so on.

OT: I would have to agree with Maurice that Mrs Downey's cognitive skills, including memory, attention, and orientation, seem to be relatively good. This helps a lot from an OT point of view because it means that you, Mrs Downey, can learn new skills and re-learn old ones. Right now in OT we have been focusing on activities of daily living like washing, dressing, grooming. You have a rather dense hemiplegia, or weakness, with your right arm,

which unfortunately has shown little improvement in the past few weeks with the exception that the swelling has gone down and the pain seems to have subsided. Even so, you can brush your teeth and comb your hair with your left hand now and you can dress your lower body. *(OT addressing team:)* I have some questions for the family regarding discharge planning and safety issues. Do you think we should talk about that now?

SW: I would suggest that the rest of the team contribute their observations and impressions first and then we go on with discharge from there.

Team *(agrees with plan)*

PCN: Mrs Downey, you certainly are a delight to work with from a nursing point of view. You are motivated to help out in your care and recognize when you should be trying something on your own and when you need help. Your mood is slowly getting better, although those tearful moments still come sometimes, and justifiably so!

Mr D.: Is there anything we can do to make her feel better?

PCN: I think bringing in the kids for regular visits is important. The huge smile that she wears while they are here says it all. You can also go for strolls around the hospital grounds or go grab a coffee.

Mrs D. *(now crying)*

SW: Mrs Downey, you have every right to cry. You've experienced a lot of changes and losses since your injury. I don't think any of us could begin to understand how you must feel some days. Please take all the time you need.

Ms M.: We – the family, that is – were actually wondering if it might be possible to take my sister home for a weekend visit?

OT: Actually that would be a great idea. Patients often do this as part of their rehabilitation. I wonder though if an entire weekend might be too much at first. How about starting with a day and if all goes well we can help you arrange for an overnight visit for the following weekend? Whose house were you thinking of taking her to?

Mr D.: That would be our house, home.

OT: How accessible is the house? Do you have stairs going up to the front door? Are your doors wide enough to fit a wheelchair through?

Mr D.: Actually we have a long driveway that brings us close to the front door and there are no steps. We would have to find a way to get her up the three steps that are just inside though, that is, from our entrance to the main floor.

OT: Maybe we could meet sometime this week and look at the possibility of fitting a temporary ramp. Do you think you could take some measurements within the next few days for me?

Mr D.: Oh sure, yeah, I can certainly do that.

OT: Great. Let's plan on taking a few minutes after this meeting to set up an appointment to meet sometime this week.

PCN: We would still have to think about toileting when she is at home. Barb, could you meet with Mr Downey and Margaret at the same time this week to arrange for the delivery of a commode to the house for this coming weekend?

HCR: Oh sure, that would be no problem. I'm sure home care will have a role in your discharge home in the future, Mrs Downey. It would only serve you well to start the paperwork earlier rather than later.

PT: Plans for a day visit complement our goals nicely in physio. I've noticed in the last week some improvement in that right leg, Mrs Downey. Right now we are working on weight-bearing on the right but there is a good chance that you'll be able to take some steps using a walker in the coming weeks. Once we have you more mobile, the logistics of getting you home will be much easier.

SW: Speaking of home, this might be a good time to take a few minutes to discuss Mrs Downey's on-going therapy needs after her stay here with us. I think the team would agree with me when I say that Mrs Downey could certainly benefit from on-going rehabilitation. Now that Mrs Downey is MRSA-negative, we could consider referring her to the intensive stroke rehabilitation programme. I daresay one of our goals would be an eventual discharge home. Am I correct?

Mrs D. *(nods head vigorously)*

Mr D. & **Ms M.:** Yes. Absolutely!

SW: Wonderful, then. We'll make the referral asap. Does anyone from the team have further contributions? Mr & Mrs Downey, Ms Martin, do you have any further questions?

Team: Nope.

Mr D. & **Ms M.:** No, everything has been well explained. Thank you very much for your time.

Simulation Task

Get together with three to five other students and think of another case story. Decide which information you need and take some notes of the various treatment approaches. Then perform your own multi-professional team conference discussing the patient case in question.

5.7 Team Meeting for an IEP (Individualized Education Plan) in the USA

When a child becomes eligible for special education in the USA, a team from the school district meets to determine if and when a student needs special services or supports (OT, PT, SLT, psychological counselling, etc.) for his or her inclusion in regular classes ("mainstreaming" according to the *Individuals With Disabilities Education Act Amendments of 1997 – IDEA 97)*. An IEP team collects and reviews information about a student's strengths and needs in his or her context, i.e. the information comes from various sources, including parents, therapists, educators and others involved with the student. The IEP team is required by law to determine the child's educational needs, establish individualized annual goals and then identify the necessary supports and services to meet these needs.

The following is a case example of an IEP meeting for Kathy, a 5-year-old girl with Down's syndrome in general education preschool. Down's syndrome is a disability under the classification of mental retardation. Kathy's parents (P) are present, as well as the regular education teacher (T), the special education teacher (SEdT), the school psychologist (SP), a speech and language therapist (SLT), and an occupational therapist (OT). The IEP team has identified a need for specially designed instruction around art activities and all written and drawn expression because Kathy requires accommodations to participate in the curriculum requirements of colouring, drawing and manual activity. Kathy needs accommodations that support her participation in classroom activities and assignments.

The school psychologist (SP) opens the meeting:

SP: A very good morning to everyone and I would especially like to welcome Mr and Mrs Kerkovian today. I know how difficult it is to find the time in your busy work schedules for these meetings.

P: It is very important to us that Kathy is getting a good education and that she is happy at school. This has not been the case lately. She cries every morning and rubs her tummy as if she is in pain. We have been to the doctor and he can't find anything wrong with her. So maybe something is not right at school?

T: This is interesting. As soon as Kathy comes into the classroom, her face lights up and she goes straight to the doll corner and begins playing with Julie and Marcus. When we start with table activities, especially colouring, she starts biting her fingernails and does not participate.

SEdT: It seems to me that Kathy is avoiding manual tasks in general. One of the annual IEP goals that the IEP team decided upon at the beginning of the school year was the following, I quote: "Kathy will express legible written/drawn responses for art, maths and reading activities and assignments in the preschool curriculum."

SP: Yes, so I think it is important that we discuss why Kathy might be demonstrating this avoidance behaviour and how we all can support her participation in manual activities at school and at home.

P: We think Kathy is scared to draw. Has she been yelled at because she doesn't participate or do the other kids laugh at her attempts?

T: No, not at all. We don't put Kathy under pressure. Of course, we do try all kinds of tricks to encourage her to participate. The other children in the class really like Kathy and sometimes ask her why she doesn't colour, too.

SLT: I wonder if it has something to do with her inability to express her feelings in language. Her vocabulary has increased considerably in the last few weeks. She speaks two to three word sentences but when she gets excited or angry, she squeals or whines and does not express her feelings in words. Maybe I could work with her using simple pictograms expressing basic emotions to help her tell us through pointing what it is about colouring that makes her unhappy.

OT: I think that is a great idea and I will try to devise alternate means of expression and participation in prewriting activities. Kathy needs a reliable method for labelling pictures and papers with her name, such as letter or word stamps with ink pads, stickers or a name stencil. Another aspect is her ability to hold and use hand tools. She has difficulty using pencils and crayons. She needs very thick-shaped utensils. I can adapt special crayons to fit her hands and maybe do the same with paint brushes. In fact finger-painting may help motivate her to use colours freely, you know, without having to paint something specific, just spreading colour on a big piece of paper. Painting, colouring or writing independently is not an end goal in itself, but it would support Kathy's ability to participate in the curriculum.

SP: This might be exactly what makes Kathy so unhappy when she is required to do manual activities. Maybe she notices that she can't take part successfully and feels pressure and stress. Her teacher has just told us that she goes straight to the doll corner when she gets to school in the morning. Dolls seem to have meaning for Kathy. Is there a way we can combine dolls with manual activities?

OT: Definitely. Play is a child's work and can be very motivating for all aspects of child development. Maybe her favourite doll can "colour" with her or Kathy can finger paint a picture for her doll.

SLT: Her favourite doll could "demonstrate" feelings too, like shaking her head vigorously and pointing at a pictogram of an angry girl saying "no!" There are many ways to develop language with a talking doll!

P: Can we help out with any of this at home?

OT: Oh yes, if we all work together, we can support Kathy in all areas of her daily life. As soon as she feels understood and secure that no one will expect of her what she is not able to do, she will begin to participate playfully and of her own initiative, i.e. through self-motivation. Does she have a favourite dolly at home?

P: Kathy has a teddy bear she calls Bubu, who she carries around with her all the time and, of course, Bubu sleeps in her bed too.

OT: Good. I can give you a list of a few tasks that I work on in therapy. Bubu can do the same tasks at home with Kathy during the floor-time play session we have initiated as a home programme.

P: We are really learning a lot with the floor-time play and are having fun too. Do you think her tummy aches will go away if the pressure is off during colouring and writing activities?

SP: Why don't we all make a note of how we will approach manual, colouring or writing activities in the next two weeks and keep a protocol of how Kathy reacts. Mr and Mrs Kerkovian, you can protocol the tummy aches and either e-mail me or give me a call at the end of two weeks with the results. If her nail biting in school and tummy aches at home in the morning haven't reduced within two weeks, then we go back to the drawing board. We'll schedule another meeting and develop a new collaborative plan. Everyone agreed?

P: Thank you all for listening to us and taking this seriously. We hope this plan will work out, because it has been really hard for us to send a crying child to school every day!

OT: Collaboration is the key to success and we all want Kathy to be a happy child who develops to her full potential.

SP: I think we all agree with that statement! OK, let's bring our very productive IEP meeting to a close. We will meet again in two weeks. If any questions come up in the meantime, just give me a call. Have a good day everyone!

Active Vocabulary: Children with Special Needs

The English equivalents to these German words are used in the text. What are they?

- Anpassung = _____
- Aufgabe = _____
- aus eigener Initiative = _____
- Bodenspiel = _____
- feinmotorische Aktivitäten = _____
- geistige Behinderung = _____
- Handgerät = _____
- Integration von Kinder mit sonderpädagogischen Bedürfnissen in einer Regelschule = _____
- Lehrplanvorgaben = _____
- leserlich = _____
- Protokoll führen = _____
- Schulpsychologe/-in = _____
- Sonderpädagogik = _____
- SonderpädagogIn = _____

- Vermeidungsverhalten =_____
- Zusammenarbeit = _____

Active Vocabulary: Odd One Out

Decide which of the words listed below is *not* a synonym for the word used in the text. Please look up unfamiliar words in a general dictionary. One example has already been done for you.

scared (line 22)	(antsy) – frightened – timid
to yell (line 22)	to holler – to bellow – to gnarl
to wonder (line 27)	to speculate – to ponder – to mope
to squeal (line 30)	to crow – to scram – to whoop
to whine (line 30)	to wiggle – to weep – to wail
to devise (line 34)	to extract – to conceive – to invent
to label (line 36)	to name – to capitulate – to title
vigorous (line 55)	strong – dynamic – fretful

Exercise

Write a treatment plan for Kathy based on the information provided by the above team meeting. Feel free to make up any further information that is not given in the discussion but that you find necessary for your treatment.

Exercise

Do some research to find out more about IEPs and the role of allied health professionals in special education in the USA. Prepare a PowerPoint presentation on this topic (ca. 10 minutes) to introduce it to your fellow students.

Simulation Task

Imagine you are a member of a multi-professional team discussing a client case in an individualized education plan.
Get together in a group of three to five students and think of a particular patient case. Then decide who is going to take which role in the simulation exercise. If you like, take some notes on what you want to say in the discussion before you all start.

5.8 Neurological Patient Admission to Hospital – Example of a Hospital Medical Ward Chart Note

The following text refers to a hospital medical ward chart note of a probable patient case. In the UK and the Republic of Ireland detailed patient notes and their documentation in the appropriate patient chart are obligatory after each treatment session. In the notes the AHP records the collected patient data, the treatment applied and treatment outcomes as well as further treatment plans and goals. Writing into patient charts is a big part of the daily working routine of AHPs in British and Irish hospitals. They also form a considerable part of

written communication between the medical professions. In order to make the documentation of patient information quick and easy the AHPs, doctors and nurses use abbreviations to describe various patient aspects.

Note

You may also find it useful to refer to ► Unit 4.11 – SOAP notes.

The following example shows possible patient notes to be found in a medical ward inpatient chart. Read through them and – where necessary – check the abbreviations used in the chart with the abbreviation list in the Appendix.

Medical Notes

P/C

Stroke

HxPC

last night pt began to get unsteady on his feet, of note pt had 2 previous CVAs 3 yrs ago ē R sided weakness + expressive dysphasia

PMHx

CVA

Seizures

A.Fib.

BP↑

Meds Warfarin

Epilum

SHx

lives alone, smoker

FHx

nil

O/E

	ULL	URL	LLL	LRL
Tone	N	↑	N	↑
Power	5/5[1]	3/5	5/5	3/5
Reflexes	N	↑	N	↑
Coord.	N	↓	N	↓

Dx

re-CVA

Plan

CXR

CT Brain

OT, PT, SLT

1 In accordance to German MFT.

Physiotherapy Notes

Thank you for referral

Subjective: consents to Tx, sitting out in buxton chair, hoisted by N/S pleasant + cooperative.
Denies chest problems or sputum, coughs spontaneously.

Objective: vitals stable
Chest: AE ↓ bibasally, no added sounds
R UL flexor pattern, mild ↑ tone
AROM – 30 to 120
R LL DF present
IRQ g 4 (-)[1]
Mobilizes ē z/frame + mod. ass. x 2-3

Tx: initial assessment

Analysis: decreased AE, decreased ROM R UL + R LL as well as increased tone of the same. Requires mod. ass. x 2 to mobilize.

Plan: Rehabilitate following Bobath approach, chest expansion techniques

Occupational Therapy Notes

Referral received ē thanks.

Subjective: no c/o, consents to Tx

Objective: carried out initial Ax, pt appears to have Ø functional use of R UL

Transfer: dependent – hoist
Sitting balance poor – unable to maintain flex of hips, leans to R side

On facilitation mvt. of R UL evidence of assoc. react. L UL

Analysis: main problems at present

- sensation ↓ R UL + LL
- proprioceptive awareness ↓
- function R UL ↓
- poor sitting balance

Appears very frustrated ē low mood

Plan: will devise intervention plan to address above problems ē physio and N/S

1 In accordance to German MFT.

Speech and Language Therapy Notes

Thank you for referring this patient

Subjective: nil

Objective:

Language Ax:

Pt presents ē mild receptive + severe expressive dysphasia

Auditory comprehension: following 2 element commands, comprehension breaks down ē more complex commands.

Expression: pt accessing voc ē 75% accuracy. Word finding difficulties evident + further compounded by perseveration.
Naming accuracy 10 % accurate.

Reading: Single word level for unrelated words. Reading at single word level reduces to 40% ē distractions.

Writing: Ø writing, Ø copy at present

Pt also presents ē a mild oro-motor weakness + dyspraxia element, which further compounds speech.

Plan: Therapy focusing on auditory + reading comprehension + semantics.
Pt has been left Exs to do.

In English-speaking countries, just like in Germany, abbreviations are commonly used in the communication amongst health professionals. In the Appendix you can find an extended – though by no means comprehensive! – abbreviation list. In the various exercises in Units 4 and 5 you already came across a number of abbreviations.

Exercise

Test yourself! How well do you already know some of the most commonly used abbreviations in the SOAP format? Here are the X words from the files:

1. Ax	2. Dx	3. Ex	4. Fx
5. FHx	6. Hx	7. PMHx	8. Px
9. Rx	10. SHx	11. Sx	12. Tx

Exercise

A referral to see Mr Smithe was recently made to OT, PT and SLT. Imagine that you have just completed your initial assessment. Given the details of Mr Smithe's admitting condition as described below, what areas of strengths and areas needing improvement might you expect to see in your initial assessment? Document your findings as per your profession in SOAP format.

Admission Report from Neurosurgeon

Date of Report: 15.03.2009
Attending Physician: Dr Robbies

Mr Smithe is an 18-year-old male admitted to our Trauma Centre on the 14th of March, 2009 following a RTA. The car was reportedly T-boned by a taxi coming at high speed through a four-way stop. The driver of the car and the cab sustained only minor injuries. Mr Smithe was found LOC on the scene. On arrival to our emergency room, Mr Smithe presented with a GCS of 3 (E = 1, V=1, M = 1).
Reportedly he has no significant previous medical history. He is a non-smoker.
A CT scan (14.03.09) showed no evidence of a haemorrhage, SDH or contusion. The possibility of diffuse axonal injury, however, cannot be ruled out. An MRI was not required at this time.

Mr Smithe was at the time of arrival intubated [ETT 8.0]. A CT chest (14.03.09) revealed right rib # 6, 7 and RLL atelectasis. A referral to Internal Medicine has already been made.

A CT abdomen (14.03.09) revealed normal findings.

A CT pelvis (14.03.09) revealed left #. The Orthopaedic service has been consulted and provided orders for complete bed rest. HOB is to be raised no more than 45 degrees.

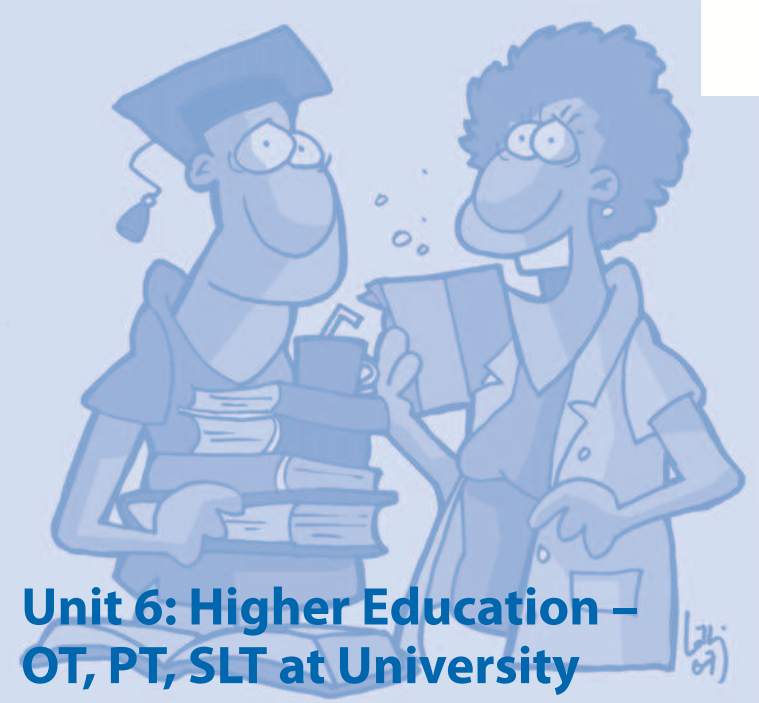
At this time, Mr Smithe has been transferred to our ICU in stable condition. He will continue to be followed by the service of Neurosurgery.

Sincerely,

_____
(Signature, Attending Neurosurgeon)

Simulation Task

When you have finished your notes on Mr Smithe, get together as a multi-professional team with an OT, a PT and an SLT and hold a team meeting based on your notes.



Unit 6: Higher Education – OT, PT, SLT at University

6.1 Differences between School and University

What are the difference between school and university?

North American and British universities typically give their newly arrived first year students ("freshers") advice on how university life is different from their experience at school. Here is some of this advice:

- students are responsible for their own time management
- students must be able to set priorities
- students spend less time in class each week and often have hours between classes
- professors expect you to initiate contact if you have questions or need assistance
- professors expect you to read the books on the reading list for their seminars
- professors may not summarize main points on the board

Questions

1. **Do you agree or disagree with the individual points mentioned? What else can you think of?**
2. **In your opinion, what are essential study skills for students?**

6.2 Study Skills: Academic Reading

Additional info online

Experienced readers employ various specialist skills when reading English-language academic texts. These skills are crucial to their success at understanding the content and contribute to improving their overall competence in English. The following tips are combined with questions to help you reflect on your own reading techniques. You can answer these questions on your own or discuss them with fellow students. If you don't use a specific text in class, choose your own English-language academic text to test the following strategies.

1. Preparation

Make sure that you have enough **time** and that you are in the right **mood** to read an academic text.

1a. Do you know how much time you need to read one page written in academic English? If not, test yourself and find out!

1b. Which mood or atmosphere do you need to be able to concentrate on an academic text?

Make sure you have all the necessary reference materials at hand.

1c. In your experience, which reference materials are useful for reading an English-language academic text? Make a list for future reference.

2. First Encounter with the Text

Prediction makes your reading faster and more effective. Efficient readers predict what they are going to read and then check how the content of the text matches up to these predictions. Predictions change as more information is received from the text. As a starting point, readers must think of the right **questions** to ask the text and themselves.

Read with a purpose and understand the purpose of different texts.

Interact with the text to draw connections to your own background knowledge.

2a. Which questions should you address before starting to read the text properly?

2b. Now have a look at the text you have chosen and answer the questions you established above.

3. Getting the Gist of the Text

Before you start reading a journal article in detail, check whether there is an **abstract** and read this first to get a concise overview of the text.

Note

If you find it difficult to understand what the abstract is about (e.g., because the topic is unfamiliar to you), the article will probably be a difficult read for you, too. Forewarned is forearmed!

Try to decide which **type of text** you are dealing with as certain types of texts tend to have a specific structure. This will help you to predict what kind of information is addressed in which part of the text.

Read the **introduction** and the **conclusion/summary** first as they probably will provide you with a good summary of the text so that you know what to expect from it – and what not.

Skim through the text and look for **main ideas;** try to grasp its overall structure.

Note

Skimming = quickly looking through a text to get an idea of what the text is concerned with (used when reading magazines, newspaper articles, etc.)
Scanning = locating specific information in a text (used when searching a text for a particular word; also used in looking at timetables, charts, etc.)

3a. What is the structure of your text?

Read **paragraph** by paragraph, focussing on the content of each paragraph separately as – ideally – each paragraph of a text is a unit dealing with one particular idea.

In a well-written text each paragraph is a unity dealing with one particular aspect of the subject matter. A typical paragraph consists of the following three parts: The first sentence is the key sentence that introduces the topic. It is followed by a number of sentences which develop this aspect further. The last sentence provides a summary of the whole paragraph and/or makes a connection to the next idea, i.e. the following paragraph. You may find reading an academic text in English easier if you try to grasp its general drift by concentrating on the first and the last sentence of each paragraph when you read it for the first time.

4. Tackling Language Problems
Check whether you have any problems with grammar, syntax (sentence structure), vocabulary or pronunciation.

4a. Do you have any language problems concerning your text? Can you cope with them on your own or do you need help? Where can you turn for help? Which reference materials and other sources could you consult?

Try to deduce the meanings of unfamiliar words from the context in which they appear or from related words you already know (e.g., "ageing" as deriving from "age").

Note

Guessing and deducing meanings can only get you so far. Ultimately, you still need to look up important words using a general and/or technical dictionary!

4b. Which unknown words from your text would you look up?

Look for **key words** and make sure that you understand them properly.

4c. What are the key words in your text?

Make sure that you know the right meaning of **linkage words** (e.g., because, however, as, nonetheless, since, whilst, due to, etc.) as they establish logical relationships between ideas in a text.

5. Working with the Text
Read the text for a second time and use your favourite technique(s) of **marking and storing important information** (underlining, outlining the structure in the margin, highlighting key words, drawing mind maps, making excerpts, etc.).

Highlight and/or copy interesting vocabulary, idioms and grammatical structures – if you really want to expand your vocabulary, this is the thing to do!

5a. Do you have a particular system of storing new vocabulary?
5b. Which vocabulary from your text do you want to store?

Evaluate the text critically, determining whether you agree or disagree with the author. A scientific paper may have serious flaws. There are various guidelines to help you appraise e.g. the statistical validity of a paper or the methodology of a qualitative study. When reading a theoretical text you should always reflect on whether the author's arguments are coherent and convincing.

5c. Concerning your text, are there any points where you don't follow the author's argument or where you disagree with the author? What is your standpoint?

Active Vocabulary: Talking about a Text

Here is some useful vocabulary for talking about texts. Please match the English terms with their correct German equivalent. The first one has already been done for you as an example.

1. (table of) contents	A. Abbildung
2. abbreviation	B. Abkürzung
3. annotation	C. Absatz
4. appendix	D. Anführungszeichen
5. caption	E. Anhang
6. chapter	F. Anmerkung
7. character	G. Bildunterschrift
8. diagram *or* figure	H. Buchstabe
9. excerpt *or* extract	I. Diagramm, graphische Darstellung, Schaubild
10. footnote	J. Exzerpt, Auszug
11. graph *or* curve	K. Fußnote
12. heading	L. Inhaltsverzeichnis
13. illustration	M. Kapitel
14. letter	N. Klammer
15. paragraph	O. Kurve
16. parenthesis *or* bracket	P. Tabelle
17. quotation	Q. Titel
18. quotation marks	R. Überschrift
19. summary	S. Zeichen
20. table *or* chart	T. Zitat
21. title	U. Zusammenfassung

6.3 Study Skills: Academic Writing

Additional info online

Research is becoming an increasingly important aspect of the professional role of therapists. Recent endeavours in many countries to reduce costs in the health care sector have made it necessary for health professionals to prove the effectiveness of their services by carrying out research and disseminating research findings (by publishing articles or books, presenting papers or posters at conferences, etc.). In this context, two types of academic writing are particularly important: the **research report** and the **research proposal**. As far as style is concerned, academic writing aims to be precise, semi-formal, impersonal and objective. The actual format of a paper may vary considerably depending on its purpose and methodology (e.g., quantitative vs. qualitative approach) as well as on the formal requirements of the specific educational institutions or publishing media

it is submitted to. Accordingly, you always need to familiarize yourself with the guidelines and style manuals appropriate to the specific occasion.

Research Report

Three principal forms of research report can be distinguished: a dissertation or thesis as part of the assessment on an educational programme, a publication in a professional journal going through a process of peer review and an "informal" research report in a non-peer-reviewed publication, e.g. a magazine or newspaper (French & Sim, 1993, p. 91).

A research report usually contains the following key elements: title, abstract, introduction, method(s), results, discussion, conclusion, acknowledgements, references, appendices.

Note

Many research reports do not contain a separate conclusion as the final paragraph of the discussion section already fulfils this function. The structure of these reports is commonly referred to as the IMRAD-structure of empirical research texts: Introduction, Methods, Results, And Discussion.

Exercise

What is the purpose of the following sections of a research report? Link them to the items listed below. The first one has already been done for you as an example.

a) Introduction
b) Methods
c) Results
d) Discussion
e) Conclusions (or Summary)

1. to summarize the most important findings of the study and the most remarkable conclusions to be drawn from them [e]
2. to outline the structure of the paper [__]
3. to describe the problem investigated [__]
4. to interpret results [__]
5. to provide an objective report of all the main results of the study supported by selected data [__]
6. to briefly discuss the research question, the method used, hypotheses and possible limitations of the study [__]
7. to suggest theoretical implications, additional research and/or practical applications of the results [__]
8. to describe the methods and procedures applied and the individual steps taken during the actual conduct of research [__]
9. to state the overall aim of the study [__]
10. to report quantitative data in summary form by means of descriptive statistics [__]

11. to describe the research design that was adopted (e.g., a randomized controlled trial, a questionnaire survey or an expert interview) [__]
12. to review existing research literature as an explanation of the scientific context [__]
13. to critically appraise any shortcomings in the research design or the data collection methods employed [__]
14. to analyse quantitative data by using inferential statistics [__]
15. to describe the patient sample, materials, interventions and equipment used [__]
16. to state whether an answer was provided to the research question [__]
17. to give a brief overview of the whole report [__]
18. to order multiple results logically, e.g. from most to least important [__]
19. to propose plausible explanations for the observations [__]
20. to explain data collection procedures as well as data analysis in sufficient detail so that other researchers are enabled to replicate the study [__]
21. to state whether the hypothesis presented in the introduction was retained or rejected [__]
22. to compare the findings with those of other research literature [__]

Research Proposal

A research proposal, also called protocol, may be required of you if you apply for funding or for the approval of an ethics committee. A research proposal is similar in structure to a research report. As it outlines a future research project, however, it obviously contains no results. There is also no discussion section. Instead, expected results, a budget and detailed available resources are listed and pilot data may be included. The actual format and content of the research proposal also depends on its purpose, e.g. applying for research funding vs. passing a student assignment. Sometimes guidelines are sent with research proposal forms; these should be read and adhered to carefully.

Verb Tenses Used in Writing Research Reports or Research Proposals

Use the **present tense** for the introduction to describe the overall context and your current thinking about a research problem. Use the **past tense** or the **present perfect** for other research literature cited but the **present tense** for its results.
Use the **past tense** for the methods section of a research report.
Use the **future tense** when writing the methods section of a research proposal.
Use the **past tense** for the results section.
Use the **past tense** in the discussion section for your own work but the **present tense** for previously published work.
Use the **future tense** for the Methods and Expected Results section of a research proposal.

Writing an Abstract

The purpose of an abstract (sometimes also called summary) is to give a concise overview of the whole text so that potential readers get an idea of what the report, thesis, article, etc. in question is about and can decide whether it is worth reading for their particular research interest. Abstracts are published in journals (and some books) right before or after the text they summarize. They are usually also available from scientific databases (Medline, etc.). In many databases abstracts are accessible free of charge even when the full text version is not.

The maximum length of an abstract may vary from 50 to more than 300 words, depending on the individual publishing requirements. In any case, an abstract needs to be relatively short. As a consequence, abstract writing can be compared with precision writing. According to the Manual of the APA (American Psychological Association), a well-written abstract is accurate, self-contained, concise, specific, non-evaluative, coherent and readable. The abstract is written after the original text is already finished so key points can be extracted from each section in a condensed form. Considerable time is then needed to revise the abstract several times until it is concise enough.

The abstract states the main objectives, describes the methods, summarizes the most important results and states major conclusions as well as the significance of the results. Its structure is comparable to that of the actual report. Abstracts for empirical studies require subheadings. The abstract does not contain any information that is not in the text itself, specific details from the text, reference to figures, tables or sources.

Traditionally, the passive voice has been strongly preferred in scientific writing (e.g., "It is suggested…" rather than "I suggest…") but nowadays researchers consider the active voice to have its merits, too, as it is clearer, more direct and more concise. Abstracts are often written in the active voice to conserve space.

6.4 Study Skills: Presentations and Discussions

There are two main stages involved in presenting a paper: the preparation stage and the presentation stage.

Note
In the Appendix you will find a list of useful phrases for discussions.

Some Tips for Preparing and Presenting a Talk

- in writing up the topic remember that your presentation needs a clear structure
- take into consideration how familiar your audience is with the topic – explain difficult concepts and summarize important points
- include a formal, recognisable introduction and conclusion in your presentation
- check and practise the proper pronunciation of technical terms and key terms
- rehearse your presentation at home so that you know which phrases work and which are too complicated for a spoken text
- find out how much time you have been allowed for your talk and check the actual length of your presentation by rehearsing it
- do not forget to welcome the audience at the beginning and to thank them for their attention at the end
- speak freely and keep eye contact with your audience
- use outline notes to give your talk (but bring along the full written version to be on the safe side)
- be prepared to answer questions from the audience

Questions

1. **Can you think of other tips to add to this list?**
2. **Which things can go wrong when giving a talk? What can you do to prevent such mishaps?**

Here is an example of a presentation in English:

Stuttering Treatment Programme of the American Institute for Stuttering (AIS)

"Good morning, ladies and gentlemen. Today I am going to talk to you about the treatment programme of the American Institute for Stuttering for people who stutter. My talk is divided into the following three parts: firstly, the definition of and possible aetiologies of stuttering; secondly, the characteristics of stuttering; and lastly, intervention. Please note that this last point is anecdotal and based on my own experience as an intern at the AIS.

We will start with a definition of stuttering. The symptom is defined by the World Health Organization as "speech that is characterized by frequent repetitions or prolongation of sound or syllables or words, or by frequent hesitations or pauses that disrupt the rhythmic flow of speech". A person who stutters can cognitively formulate what it is that they would like to say but has difficulty physically producing the intended message or speaking.

In an attempt to answer the question of what causes stuttering, researchers have put forward several theories; however, the exact aetiology of stuttering remains unknown. The most traditional theories suppose that stuttering is due to an abnormality of some physiological process, for example, abnormal tongue function, structure or both. Other theories suggest that stuttering is a question of cerebral dominance. It is part of our general knowledge that for a large part of the population speech and language functions are located on the left side of the brain. Research in the area of stuttering and brain scanning, however, have revealed that speech and language functions are located on the right side of the brain in people who stutter. In addition to studies focusing on physiology and brain functioning, the importance of genetic influences and stuttering also has been investigated. Research focusing on the family histories of people who stutter has revealed, very clearly, that a predisposition to stuttering exists. It is also a fact that stuttering affects males more than females at a ratio of four to one. Finally, the role of emotional or psychological factors causing or influencing stuttering behaviours has been considered. Theories focusing on these factors assume that stuttering is a result of repressed or neurotic conflict within the subconscious. In summary, although there is no general consensus that one of the above theories alone explains stuttering, it is generally agreed that stuttering is influenced by both "nature" and "nurture". That is, a percentage of the population is presumed to be hard-wired for stuttering. The frequency of its occurrence may then depend on environmental factors.

I'd now like to turn the focus of this presentation to the characteristics of stuttering. Please note that the following descriptions are defined by the AIS. A distinction between physical, secondary and avoidance behaviours is made.

The physical behaviours associated with stuttering can be defined by sound, syllable or word repetitions (e.g., mi-mi-milk; wheel-wheel-wheelchair), prolongations (e.g., m-m-milk) and blocks (e.g., ccccccat). Repetitions and prolongations occur as a result of the articulators trying to "push" the sounds or words out. Blocking, on the other hand, is a result of the dampening of signals from the brain to the vocal folds. Due to an increase in vocal fold tension simultaneous to when a stutterer begins speaking, the vocal folds adduct or "close" instead of abducting or "opening".

Secondary behaviours are the body behaviours or facial expressions that occur during the act of speaking. There are several different types of so called "secondaries". The physical behaviours noted above can be considered of a "secondary" nature. Jerking the head or closing the eyes as a result of physical struggle while attempting to speak is another kind of "secondary" behaviour. Alternatively, some stutterers hit their knees, click their tongues or use starter words, like "um" or "you know". Secondary behaviours such as avoiding eye contact or covering the mouth are also frequent in occurrence, these being the result of the stutterer's attempt to conceal his or her problem.

Avoidance behaviours are defined as the strategies or mechanisms that a stutterer uses in an attempt to compensate or cope with his or her stuttering. This may include, for example, avoiding or substituting particular words, spelling words, rephrasing sentences, avoiding to speak/pretending not to know the answer and/or, "postponements" (i.e., pausing before a

difficult word). People who stutter often avoid what for them is a difficult communicative situation (e.g., answering the phone) in an attempt to avoid embarrassment or frustration. People who stutter often also avoid particular career choices that involve a lot of public speaking, lecturing or presentations (e.g., teaching, politics) and replace them with those that have less verbal communication demands.

Taking into consideration all the above issues, let's next take a look at a treatment programme for stutterers. The American Institute for Stuttering offers a treatment programme comprising five phases.

Phase 1: Identification. In this phase exercises are provided to help stutterers increase awareness of their stuttering behaviours. Identification includes learning "why" a person stutters, "what" a stutterer does, and "how" a stutterer feels. An important component to this phase is meeting and working together with other people who stutter. In this way, persons who stutter have an opportunity to "identify" with others who stutter and learn that they are not the only ones. A safe environment is created whereby members are able to identify stuttering behaviours by observing oneself and each other. This may be done by use of a mirror and working together in pairs or via videotaping. In fact, everyone at the AIS is videotaped on their very first day. Each videotape is eventually observed by the entire group and behaviours not yet recognized by the client in question are pointed out (sometimes through enactment by another group member) and further explored.

Phase 2: Desensitization. As already mentioned, stutterers put a lot of energy into hiding stuttering and avoiding speaking. Desensitization is designed to help a person who stutters become open, comfortable and more at ease with their stuttering. An exercise in this phase, for example, may involve making a telephone call and telling the listener that stuttering might occur. This kind of exercise is called "self-advertising". Completing stuttering surveys are another method of desensitization. Questions about stuttering are posed to family and friends and, on occasion, even strangers. Research has demonstrated that the best location and time to complete a stuttering survey is in the park during lunch time and that most strangers are quite interested and willing to be interviewed.

Phase 3: Voice and Speech Management. In Phase 3 clients learn to manage the physical skills associated with voice and speech production. Breathing is a major component of this phase. For controlled vocal production a coordinated breathing pattern is necessary and clients learn breathing in four phases. First, exhalation occurs so that the diaphragm returns to its relaxed position. Second, inhalation occurs whereby the diaphragm lowers and the ribcage expands. During this stage the speech articulators are also to remain relaxed. Third, exhalation occurs once more, this time to force the vocal folds open. Lastly, breathing is combined with voicing, starting with the production of prolonged vowels (e.g., /o:/). Exercise of the above breathing pattern can be divided into three types of practice: covert, semi-overt and overt. Covert practice involves only breathing (Phases 1-3). Semi-overt practice involves breathing and voicing (Phases 1-4). Overt practice involves the use of the whole speech mechanism: breathing, voicing (Phases 1-4) and articulation. Strategies such as "prolongations" and "pull outs" are also learned at this time to reduce or eliminate physical

behaviours such as blocking. The application of controlled breathing and management strategies, once mastered at the sound level, are then applied to the production of words. Clients are given word lists with single syllable words (e.g., "pat"), two-syllable words (e.g., "sunny") and three-syllable words (e.g., "national").

Phase 4: Attitude Modification. The psychological and emotional components of stuttering are addressed in Phase 4. Relaxation and stress management also are part of attitude modification.

Phase 5: "From Clinic to Real Life". By this stage clients should be ready to take their newly acquired skills and apply them in communicative environments outside of the programme. Clients also are now entirely responsible for the maintenance of these new skills. This stage is often met with fear at the onset and aids such as a memory card with hints of what mental, attitudinal and speech tools to use are often provided to help with the transition from clinic to real life.

In conclusion, clients leave the programme with improved self-confidence and, importantly, improved fluency in their speech.

Thank you very much for your attention. If there are any questions, I would be happy to answer them at this time."

Organization and Style of a Presentation

The speaker followed the various steps required of a clearly structured presentation:

- greeting the audience
- introducing the topic of the talk
- outlining the talk
- dividing the main part into various points (introducing the first main point, concluding the first main point, introducing the second main point, etc.)
- summarizing
- concluding
- inviting questions from the audience

Exercise

Identify the various steps of the presentation from the text and have a look at the phrases used by the author. Can you think of other phrases in English that would serve the same purpose? Write these down and then compare them with the list of phrases in the Appendix.

Exercise/Simulation Task

Below are some suggestions for presentation topics. Alternatively, use a topic of your own choice.

- Animal-Assisted Therapy
- Aphasia and Bilingualism
- Assessment and Treatment of Swallowing Disorders
- Clinic Clowns
- Coping with Chronic Back Pain
- Health and Illness in the 21st Century

- Hospice and Palliative Care
- Neurological Physiotherapy
- Occupational Therapy with Street Children

Think of a good, clear structure and prepare a brief presentation (8-10 minutes) to give to your fellow students.

A Word of Advice to the Audience

Try to be prepared on the topic, to give feedback on the presentation and to ask questions as this shows that you are interested in the work presented by the speaker. Participate in the discussion.

Active Vocabulary: Being a Participant in a Discussion

What do you say if you want to…

- … contribute to a discussion?
- … interrupt someone?
- … have a point clarified?
- … give your opinion?
- … make a suggestion?
- … add another point?
- … express agreement or disagreement?

Make a list of all the phrases you can think of. Then try to organize them in the following way:

polite interruption	neutral or discrete interruption	rude interruption
weak expression of opinion	**neutral expression of opinion**	**strong expression of opinion**
agreement	**partial agreement**	**disagreement**

Compare your list with the phrases given in the Appendix.

Note

In the United Kingdom in particular, disagreement is usually expressed in a more polite and more subtle way than in Germany. It is often smart to start off with a point of agreement or recognition of ability (showing respect for the speaker) before mentioning a point of disagreement: "I think your considerations concerning … are very well developed, but on this one point, I seem to differ from your interpretation." Disagreement as such is also put in more polite terms, for example: "I'm afraid I can't quite agree with you" rather than a blunt "I don't agree with you".

Exercise

Practise your role as a member of the audience. Which questions could you ask concerning the above presentation on "The Stuttering Treatment Programme of the American Institute for Stuttering (AIS)"? You could try to clarify muddy points, ask for further information related to the topic or try to learn the speaker's opinion on points you find essential in this context.

Simulation Task

Have somebody give an actual presentation using the text "Stuttering Treatment Programme of the American Institute for Stuttering (AIS)" or one of the presentations you prepared on a topic of your choice and practice the communication between speaker and audience.

6.5 A Short Overview of Higher Education in the UK and the USA

Higher Education in the UK

Higher education in the United Kingdom is provided by **three main types of institutions:** 1) universities, 2) colleges and institutions of higher education and 3) art and music colleges. In 1992, the **polytechnics** were given university status and took university titles. Nearly all UK universities and higher education colleges are **publicly funded** by central government. Additionally, they receive funding from student **tuition fees**, which amounts to more than £1,000 for British students per year, with overseas fees being even more expensive than home fees. Most universities are divided into **faculties** (e.g., Faculty of Health Studies) which may be subdivided into **departments** (e.g., Department of Allied Health Sciences).

Undergraduate Education in the UK

About one third of young people in the United Kingdom go on to higher education at the age of 18. Although most **undergraduate** (or **first**) **degrees** in England, Wales and Northern Ireland take three years to complete, degree courses in OT, PT or SLT are usually **honours degrees**, which take four years and require the submission of a thesis. All applications for undergraduate study are processed through the Universities and Colleges Admissions Service (**UCAS**). Applicants need to apply for entrance to a specific course of study at

a specific university. OT/PT/SLT **entry requirements** in the UK are normally five GCSE passes and at least two, usually three, A levels, or equivalent, with a certain minimum grade, including one or two in a science subject.

Tuition consists of a mixture of **lectures**, **lab sessions**, **seminars**, **"tutorials"**, i.e. weekly one-on-one or small group discussions with a "tutor" or professor. Students are mainly graded through a mix of **continuous assessment** (a combination of written work and oral examinations throughout the year), a **final dissertation** and **final exams**. Graduates, i.e. students who have successfully completed their undergraduate studies and obtained a **bachelor's degree**, may go on to study for a further degree, often a master's degree or a doctorate.

Graduate Education in the UK

For allied health professionals it is quite common to **gain experience on the job** for some years and then go back to university to do a master's in the field in which they wish to specialize. UK universities award two basic types of master's degrees: on the one hand, there is the **research master's**, which normally takes two years to complete and mainly consists of independent work with little – if any – taught coursework. On the other hand, there is the **taught master's**, which consists of coursework and a dissertation and typically takes one year to complete.

At the **postgraduate level**, students can complete a **Ph.D.** (doctoral degree) in three or four years. The traditional British Ph.D. has less coursework and more independent research than its US counterpart. To earn a Ph.D., you will need to produce a **thesis** – 70,000 to 100,000 words. For all graduate studies, applicants need to apply directly to the university of their choice.

Higher Education in the USA

Americans often use the word "college" as shorthand for either a college or a university and simply talk about **"going to college"** rather than "going to university". In the USA the term "college" firstly refers to an independent institution of higher learning that offers courses to undergraduate students leading to a bachelor's degree, but colleges can also be components of universities. A **large university** typically comprises several colleges, graduate programmes in various fields, one or more professional schools (e.g., law school, medical school or school of allied health) and one or more research facilities.

All the states and even some cities have their own **public university**. Although these institutions usually charge tuition, the fee often is considerably lower than that charged by comparable **private colleges or universities**. Some public universities, like the universities of California and Virginia, are widely considered to be on a par with the Ivy League, an association of eight prestigious private schools including Harvard and Yale. In general, competition to get into one of the more renowned schools is quite strong.

Undergraduate Postsecondary Education

Almost 40% of young people in the United States receive higher education. As an **entry requirement** to college or university, students in the USA need

to sit a standardized test, e.g. the **SAT** (Scholastic Aptitude Test) or the **ACT** (American College Test). Whereas students in the United Kingdom specialize in a subject area and usually take courses only directly related to this subject, students in the USA normally take a range of **liberal arts requirements** during the first two years of their undergraduate studies, so a bachelor's degree usually takes four years in all. A college student takes courses in his or her "major" field, i.e. his or her main subject, along with "electives", i.e. courses that are not required but chosen by the student. To check a student's overall progress, the university calculates a grade point average (GPA).

Graduate Postsecondary Education

The master's degree represents the second stage of higher education and is the first advanced (graduate) degree awarded. US master's degrees may be **taught** (without thesis) or **based on research** (requiring the completion of a research thesis) and may be awarded in academic or professional fields. Most master's degrees are designed to take two years of full-time study. Students in North America do an **undergraduate degree in a less specialized field of study** (e.g., linguistics) and then start their education as an OT, PT or SLP at the graduate level (= **graduate entry-level programme**).

The **research doctorate** represents the third and highest stage of higher education in the United States. This degree is not awarded by examination or coursework only, but requires the ability to conduct independent, original research. Most doctoral degrees take at least four or five years of full-time study and research after the award of a bachelor's degree or at least two to three years following a master's degree. The most common degree is that of doctor of philosophy (**Ph.D.**).

Additional info online

Active Vocabulary: Higher Education I

The English equivalents to these German words are used in the text. What are they?

- Fachhochschule = _____ (BE)
- Studiengebühren erheben = _____
- vor dem ersten Abschluss = _____
- Studiengang = _____
- Zulassungsvoraussetzung = _____
- Mittlere Reife = _____ (BE)
- Abitur = _____ (BE)
- Vorlesung = _____
- Laborstunde = _____
- Abschlussarbeit = _____
- Abschlussexamen = _____
- mit/nach erstem Abschluss = _____
- erhalten, erlangen = _____
- Promotion = _____
- Doktorandenniveau = _____
- Studienangebot auf dem Master- und Doktorandenniveau = _____

- Forschungseinrichtung = _____
- Universitätsabsolvent = _____

Questions

1. How are universities funded in the UK?
2. What is special about doing a degree in OT, PT or SLT in the UK?
3. What is the role of UCAS in the UK?
4. What is the requirement for doing a master's degree?
5. What different types of master's degree are there?
6. What are the various meanings of the term "college"?
7. What is the difference between private and public colleges or universities in the USA?
8. What is the role of the SAT or ACT?
9. How can the doctoral degree in the USA be characterised?

Exercise

Do you have any further questions about the topic? In this case do some research to find out more.

Simulation Task

Imagine you are an exchange student in an English-speaking country and you are asked to explain higher education in Germany. Get together with a partner and practise asking and answering questions about this topic.

Active Vocabulary: The Things that Students Do… (Higher Education II)

Additional info online

Match the German expressions with their English equivalents. The first one has already been done for you as an example.

1. to attend *or* take *or* do a course	A. auswendig lernen
2. to write an essay	B. das Studium abschließen
3. to take *or* sit an exam	C. die Abschlussprüfung ablegen
4. to pass an exam	D. studieren
5. to fail an exam	E. ein Praktikum absolvieren
6. to learn by heart	F. eine Aufgabe abgeben
7. to practise	G. eine Hausarbeit schreiben
8. to hand in an assignment	H. eine Prüfung bestehen
9. to go to university *or* to study at university	I. eine Prüfung ablegen
10. to write a (seminar) paper	J. eine Prüfung nicht bestehen
11. to do one's finals	K. eine Vorlesung besuchen
12. to obtain a degree	L. einen akademischen Grad erwerben
13. to attend a lecture	M. eine Hausarbeit schreiben
14. to graduate	N. einen Kurs belegen
15. to be on (clinical) placement	O. einen Studienplatz bekommen
16. to gain a place at university	P. üben

Additional info online

Active Vocabulary:… and Some Other Useful Expressions (Higher Education III)

1. oral exam	A. Abschlussprüfung
2. professional training	B. akademischer Grad
3. elective	C. Aufnahmeprüfung
4. final exam *or* finals	D. Berufsausbildung
5. entrance examination	E. DozentIn
6. marks (BE) *or* grades (AE)	F. Einschreibung
7. instruction *or* tuition (BE)	G. Fachbereich, Fakultät
8. further education (BE) *or* continuing education	H. Fachhochschule
9. department	I. Hörsaal
10. faculty	J. mündliche Prüfung
11. lecturer	K. Noten
12. entry requirements *or* admission requirements	L. numerus clausus
13. restricted entry	M. Praktikum im Rahmen des Studiums
14. tuition fees	N. Seminar, Institut, Abteilung
15. enrolment	O. Stipendium
16. lecture hall	P. Studiengebühren
17. scholarship	Q. Unterricht
18. academic degree	R. Wahlfach
19. university of applied sciences	S. Weiterbildung
20. fieldwork placement	T. Zulassungsvoraussetzungen

6.6 Doing a Bachelor's Degree – An Occupational Therapy Student's Perspective

Additional info online

I had been thinking about changing career to occupational therapy for a long time but was afraid of the financial commitment of being a student for so many years. When I reached a point of financial security in my life, I also happened to become friends with a group of occupational therapists, who encouraged me to apply for this course.

I applied to the **Queen Margaret University College (QMUC) in Edinburgh, Scotland**, because it has a good reputation and is located close to my home town. I decided not to apply elsewhere so was very pleased to be accepted based on my life experience, previous qualifications, application and interview. At the time I applied, QMUC offered a choice of a BSc degree or honours degree but new students now have to achieve **honours level**. I

decided to continue into fourth year and aim for the honours degree as I felt that it would benefit my personal development and may be significant for me in the future job market.

Course Content

The course offered here covers all areas of occupational therapy from interpersonal skills and activity analysis to management theories and the influence of policy on therapy. Philosophy and theory is considered central to practice and a wide variety of models are examined in relation to this. We have six (5-7 week) **fieldwork placements** (**FWPs**) spaced throughout the course and that are choices in the specialities experienced. I chose to have two FWPs in a hospital setting and the others in community settings. Two placements must be in mental health and I was fortunate to have an FWP within paediatric services and a housing/social work service as well.

A Particular Fieldwork Experience

While on placement I experienced a client whose behaviour confused me. He was a young man who had sustained multiple injuries in the past and now suffered from chronic pain which appeared poorly controlled. He displayed high dependency behaviour, very low motivation, rigid beliefs and resistance to change. Later in college I studied the effects of chronic pain at a deeper level and discovered that this is common behaviour for a person who has suffered chronic pain over a long period of time. The complexity of the destructive nature of chronic pain became clear as psychological, social, physical and economic areas are all affected. Avoidance of small, everyday tasks, such as making a cup of tea, in an effort to avoid increasing the pain can develop into general feelings of incompetence in less routine tasks. Having met the young man experiencing chronic pain I can relate better to the value of occupational therapy to help such people deal with the pain and regain self-belief regarding competence and occupational engagement. The value of interprofessional teams was also well demonstrated in this particular area.

Extra-Curricular Activities

While on the course I made use of **student services** within the college such as study techniques and financial advice. I trained as a **mentor** and mentored a student in the year below me, which was a pleasure as she was highly motivated and had a cheerful personality. When potential students visited the college I helped out and particularly enjoyed a visit by local Asian mothers and their teenage daughters.

During recent course restructuring, including the implementation of interprofessional study sessions, I was one of the **student representatives** at meetings and found the process very interesting. Presently I am a class course committee representative and attend **student parliament** meetings. This is a positive experience particularly regarding debates and exposure to a wide variety of student concerns and ideas.

The time at college seems to have gone very quickly and the fact that we are in the last three months seems slightly unreal. There is a chance that the remaining time will be the hardest of the whole course and I do feel nervous about perhaps not meeting all the requirements. However, I have learned a lot professionally and personally and look forward to a career where I can

put my knowledge into good practice. I would recommend this profession as being extremely interesting, offering diverse working environments and based on person-centred philosophies.

Sonia Wilson

Questions

1. **On which basis are students admitted to the undergraduate course in OT at QMUC?**
2. **What is the content of the course?**
3. **How are FWPs organized?**
4. **In which way was the encounter with the young chronic pain sufferer significant?**
5. **Did you have any similarly striking experience when you were on placement during your education?**
6. **What kind of extra-curricular activities are mentioned?**
7. **Why are the last three months of the course particularly stressful?**

6.7 Doing a Master's Degree – A Speech-Language Pathologist's Experience

Additional info online

To date there are nine universities across **Canada** (six English, three French) offering graduate studies in speech-language pathology (SLP) and/or audiology (AUD). Out of these nine programmes, seven additionally offer doctorate (i.e., Ph.D.) training for either SLP or AUD.

Entry Requirements

All graduate programmes require that students have completed at least a four year bachelor's degree (n.b.: in the province of Ontario students complete a thesis in their fourth year and graduate with a bachelor-**honours degree**). Undergraduate degrees may be either within the Faculty of Arts or Sciences; this does not matter so long as **core prerequisite courses** within the areas of linguistics, psychology, statistics and anatomy/physiology are completed. Some universities require that students complete the Graduate Records Examination (**GRE**) as part of the admission process and all programmes require that students write an **essay** outlining their personal reasons for pursuing the profession of SLP or AUD, their knowledge of the profession to date and, finally, evidence of volunteerism within a health care, educational or related setting.

Note

See ▶ Unit 6.9 on how to write a statement of purpose

The First Year of the Programme

After having obtained my bachelor of arts degree (major: linguistics, extended minor: psychology) at Simon Fraser University (SFU), I moved from the province of British Columbia (BC) to London, Ontario (ON), to attend the **University of Western Ontario (UWO)** to complete a three-year programme in SLP (n.b., the majority of SLP programmes in Canada are two years in duration with the exception of UWO and Dalhousie University which are three).

Our class in the first year totalled 45 students (30 SLP, 15 AUD) and together we covered **general introductory coursework** in the areas of health sciences, the professions of SLP and AUD, anatomy/physiology, phonetics,

and speech and hearing science. Simultaneous to our coursework in the first year, 25 hours of **clinical observation** were completed. That is, students received an introduction to clinical practic**e** by observing colleagues working with clients: paediatric, adult or geriatric, across a range of disorders.

It also was during this first year that students had to secure a research/thesis supervisor and declare their intended degree, either **a master of clinical science** or **master of science** degree. All students in SLP or AUD were required to declare a minor speciality in their sister profession. For example, students majoring in SLP were required to complete 30 clinical hours (= minor) in audiology. In this way SLPs were also qualified to complete a basic pass/fail pure-tone audiometric evaluation.

The Second Year of the Programme

The second year of our programme became **specialized**, i.e. students in SLP and AUD no longer took shared courses but those specific to their own discipline. In that year SLP students covered heavy **theoretical coursework** in the disorder areas of aphasia and related adult neurogenic communication disorders, motor speech, swallowing, voice, resonance, (dys)fluency, hearing, child language, augmentative and alternative communication, articulation and phonology.

It was also in this second year that students began to apply theory learnt to date to clinical practice, i.e., **practicum**. Most first clinical experiences were completed on-site at the UWO Speech and Hearing Clinic. Students completed a twelve week placement, one per semester (n.b.: one semester = either four months or twelve weeks) and were assigned one to two clients per week (i.e., per semester) for whom they were primarily responsible. Additionally, students were either assigned a "shared client" and/or a "group", in other words, two or more students were responsible for the assessment and treatment of one or more clients. Therefore, in the second year students accumulated a total of two to three hours of clinical practice per week over the span of 24 weeks. **Clinical sessions** were one to one and a half hours duration. All students were assigned a clinical supervisor. Prior to every assessment or treatment session students were required to submit a **"lesson plan"** to their respective supervisor outlining their assessment or treatment goals, rationale for choosing said goal, assessment or treatment materials, and assessment or treatment "steps" (including "sub-steps" and "super-steps"). Sessions were held in rooms with **one-way mirrors** (i.e., supervisors, other students and family members could sit and watch treatment sessions without interrupting) and every assessment and treatment session was videotaped and/or tape recorded (with the client's consent) for scoring, self-evaluation and feedback purposes. Students were required to critically appraise their own sessions and in turn were given positive feedback and constructive **critiques by their clinical supervisors**. At the end of each semester and subsequent clinical term, students were given a **course grade** by their supervisors which would then be part of the student's permanent scholastic record.

Serious **contributions to research projects** also began in the second year of our programme. Students who had declared a master's of science degree in the previous year had to assemble an **examination committee** (i.e., three

additional academic persons or professors), complete and present a **"prospectus"** to the examination committee in the first third of the second year. (n.b., in order to complete a master's degree in Canada all students are required to either complete a thesis or general research project.)

The Difference between the Master of Science and the Master of Clinical Science

Within the Faculty of Applied Health Sciences at UWO a distinction was made between master of science and master of clinical science degrees. Students seriously considering academic studies beyond a master's, i.e., students considering pursuit of a doctoral degree/Ph.D. (in the field of communication disorders or related field), were encouraged to complete a thesis. A thesis required that students either contribute to the generation of the **thesis** concept, methods and design or both and participate in an hour-long defence at the completion of their work. Students who pursued the master of clinical science avenue were often most interested in clinical work and not intending to pursue a research or academic career. They were required to complete a **research project** where the concept, methods and/or design were already formulated and perhaps even data collection already completed. They were not required to write a prospectus or defend their work. Instead they had the option to present their final work (including results) in a 15-minute presentation or write a comprehensive (written) exam.

The Third Year of the Programme

The third and final year of the SLP programme was less structured and enabled students to be more **self-directed** in their learning. Only two core courses were required (Counselling and Advanced Statistics). Otherwise, students were required to participate in a total of three seminar courses over the entire year. Seminars were small in number so that discussion was easily facilitated, offered **intense review and examination of the literature** on a specific topic, e.g. "Geriatric Communication Disorders and Dementia", and were only graded on a "pass/fail" basis. **External clinical placements** also were completed in the final year. Students completed two clinical practicums that were more intense (i.e., several clients), every day over an eight- or twelve-week period. Students were still required to present lesson plans and self-evaluations to their external clinical supervisors. A final course grade again was assigned at the end of each clinical experience. And, finally, more time was allotted for the **completion of theses and research projects**.

Christina Aere

Questions

1. **What are the requirements for a master's degree in speech-language pathology?**
2. **Is there any cooperation between SLPs and audiologists?**
3. **What is the content of the course?**
4. **What happens in the second year of study?**
5. **How are the practicums organized?**
6. **What is the difference between the master of science and the master of clinical science degrees?**
7. **How is the final year of the programme structured?**

6.8 The International Perspective on AHP Programmes

Discussion

What is similar / different about going to university in an English-speaking country compared to the German experience?

Exercise

1. **Imagine you are considering spending a year abroad at a university in an English-speaking country. What do you need to find out in order to plan your stay properly? For example, how do you gain a place at university? Or where can you apply for a scholarship? How can you gather all the necessary information?**
2. **Get together with some fellow students and document the results of your brainstorming and research process. In thinking about these questions, the following checklist may be helpful.**

Checklist: Planning Your Stay at a University in Another Country

To be planned/organized:	Information to be obtained from:	Results:

Exercise

Do some research on an OT, PT or SLT programme in any country of your choice. Decide on one particular university and scan through the information on admissions, entry requirements, fees and financial aid, curriculum, assessment, etc. on their website, then share the results of your research with your fellow students by giving a PowerPoint presentation (ca. 10 minutes).

Discussion

Which contents of the programme(s) introduced to you by your fellow student(s) would you like to see integrated into a master's programme of your own profession in Germany and why?

Simulation Task

What do OTs, PTs or SLTs do at university in Germany? Imagine you were asked to explain your own professional training to a person from another country. Get together with a partner and practise asking and answering questions about this topic.

6.9 University Application and Statement of Purpose

Prospective **graduate students** (and **international students** in general) need to **apply directly** to the university faculty or department where they want to study. Each university has its own **application form** that is usually available from their website. If not, you need to write to the departmental office and request to have the appropriate forms sent to you. Apart from the filled-in forms, the student also has to send a **list of all the subjects studied** and the **grades received** and **letters of reference** (see Unit 7.3). Most application forms include a requirement for the student to write an essay explaining his or her motivation for studying in that particular degree course at that particular university. This is commonly called an **application essay**, a **letter of intent** or a **statement of purpose**.

This essay is considered one of the most important parts of the application as it is often the only basis for the admissions committee's **evaluation of the applicant's writing skills**. Some departments specify what they want the applicant to address in this essay, but usually the instructions are vague. Here are some **general tips** for this type of writing:

First of all it is important to realize that a statement of purpose takes a long time to write properly – even for native speakers of English!

Before you start writing you need to research the programme you are applying for so that you can convincingly demonstrate how your interests match that of the university.

The general advice is to keep the statement brief if the university does not specify how long it should be.

If possible, have several good writers (e.g., graduate students or professors) look over your essay for you and offer suggestions.

When your statement is finished, it needs very careful proof-reading for punctuation and spelling mistakes.

What universities are usually interested to learn from you:

- your purpose in graduate study
- the area of study you want to specialize in
- any specific members of faculty you are interested in working with
- how your previous experiences have motivated you for graduate studies
- your undergraduate studies in general if relevant to your graduate studies
- any expertise and accomplishments in your chosen field (including research)
- other experiences (i.e., jobs, community activities, extra-curricular activities, awards, honours, etc.) if relevant to your graduate studies
- possibly your personal background and/or personal attributes or qualities that will contribute to your success at graduate school
- your future career goals and how doing this particular programme might help you to achieve them

Note

If possible, point out shared interests between your area of interest and the department's research focus as universities are looking for students who fit in well with their research programmes.
When writing about past experiences, make clear what you learned from them and why this qualifies you for graduate studies.
Do not send the exact same essay to each university you apply to but rather target the content of your essay.

Exercise: Steps towards Writing a Statement of Purpose

1. **Write a short paragraph on a memorable accomplishment in your life. What did you do? How did you accomplish it?**
2. **Write a short paragraph on an important activity you have engaged in. With whom? What role did you play?**
3. **Describe your work experience in a short paragraph. What was your job? What were your professional duties? How did you carry them out?**
4. **Look at your answers to exercises 1 – 3. What skills and qualities do you possess (e.g., being a good team-player, being well organized, etc.)? Which of these skills will help you at graduate school? How? Write a short paragraph on this.**
5. **What are your career goals? Why did you make this decision? Is there any evidence that your choice is realistic? Write a short paragraph on this.**

Excerpt from a Statement of Purpose

Here is an excerpt from a statement-of-purpose essay that was required for an application to a post-professional master of science programme at a university in the United States:

> […] I am very interested in conducting a clinical research project, eventually a case study, in community-based sensory integration. Such an occupational therapy network project would consist of the development and coordination of an individually tailored treatment plan for a child with special sensory diet needs at home and in the school setting. The child I have in mind for this study has a clinical diagnosis within the spectrum of Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS). It would be very interesting to investigate the PDD-Spectrum and the possibilities for family and community-based social integration and educational inclusion. I believe that occupational therapy is not only uniquely qualified, but responsible for the integration of children with special needs into society. After many years working as an OT in a diagnostic and therapeutic counselling centre, I have seen and experienced the effectiveness of community-based practice. In Germany, occupational therapy has moved from a strictly clinical setting to private practice settings in the community. I envision even further movement directly into the family, educational and play settings. For such an integrated community-based practice to be effective, we must prepare ourselves, as a profession, to create a more
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> ▼

holistic, flexible, communicative and interdisciplinary approach for our clients. This means we need to look at our professional roots and original goals, as well as continue our quest for neuropsychological knowledge and understanding of the complex emotions and behaviours of the human experience. I look forward to beginning this pursuit with the support of a post-professional, practice-oriented master's degree programme in occupational therapy at this university.

Exercise

Think of a specific bachelor's or master's programme you are interested in doing and try to obtain all the necessary background information. Then write a statement of purpose in support of your university application. If the university's homepage does not specify any particular requirements, stick to the rules listed above and write a maximum of two pages (1,000 words).

Unit 7: Working Abroad

7.1 The Experience of Working Abroad

The possibility of working in almost any environment with people of all types, ages, outlooks on life, etc., makes the professions of OT, PT and SLT quite exciting when you think about it. Going abroad – whether to volunteer, work or study – is guaranteed to bring you new and fantastic opportunities on top of what your profession already offers to you. Learning new therapies and techniques, exchanging knowledge, gaining new perspectives, learning the pros and cons of a different health care system, immersing yourself in a new culture and perhaps learning a new language are but a few of the advantages of going abroad. In cases of countries with limited resources, therapists often acquire the invaluable skill of learning to "make the best of what you have" while still achieving therapy goals. Volunteering, working or studying abroad is your chance to enhance the quality of life for people who may not otherwise have access to good health care. It also is your chance to improve the care you deliver to clients back home as they will undoubtedly benefit from the professional and life experiences you will then be able to bring to them.

Here are the examples of three young therapists who decided to leave their career paths in Germany in order to gain some completely different professional experience in another environment.

Charity Work: A Physiotherapist in East Africa

"Sister, Sister, welcome back!" the children shout as they jump in front of the rehabilitation centre and welcome us back from a daylong journey. The sun and the African heat of the day have gone. The children dance around the car in the darkness, greet everybody getting out of it and help to unload the ambulance.

Early in the morning we had left the village. We took a number of children with disabilities and their attendants to a paediatrician's clinic. We reached the hospital after a two-hour drive on rough roads. Kabugo, one of the kids who had been operated on the week before, was eagerly waiting to be discharged. He was looking forward to coming back to the village and his friends after a week in hospital. Postoperative therapy will take place in the rehabilitation centre near his home. His face starts shining because of the warm welcome as we reach the centre after the tiresome day.

I work as a physiotherapist in a **rehabilitation centre for children with disabilities**. Together with the staff of the medical department we take care of about 30 children. The main objective of the centre is to provide medical rehabilitation for children and youths with disabilities. Rehabilitation includes assessment, operations, therapy, etc. but also teaching and empowerment. Many different activities take place in the centre and in the villages.

The centre is run as a **community-based rehabilitation project**. Community-based rehabilitation (CBR) is a flexible approach under which a diversity of rehabilitation programmes are sheltered. The term refers to a strategy developed by the World Health Organization for the rehabilitation,

equalization of opportunities and social integration of people with disabilities.

CBR was developed to meet the needs of millions of people with disabilities living in developing countries. Only a few of them receive adequate help, due to limitations within the health service system. CBR builds on the idea that people with disabilities, their families, community members and rehabilitation workers have an interest in solving the problems of people with disabilities. This kind of rehabilitation takes place in the communities and families.

The tasks for a physiotherapist within a CBR project are quite different compared to working in Germany. Most of the children have not been seen by a physician before. As such, it is important to assess the children and to discuss with their parents what to do. The social situation of the family might influence therapy plans and objectives. Beside duties in the medical area, I do a number of administrative tasks, teaching and counselling.

All in all I have gained very exciting, challenging and joyful experiences.

Ute Rüdiger

Practical Experience as an Occupational Therapist in the Southwest of Africa

My first job as an occupational therapist led me to the southwest of Africa! I worked there on an **educational project giving youngsters "one last chance"**. Prison, for example, might otherwise be their fate. These boys and (few) girls from Germany, Switzerland and Austria come to Namibia for about one to three years. Some have to work on the farm, where they stay with their integration family. Every pupil has to do at least one school class through the ILS, a "do-it-yourself" school programme. As this is rather atypical fieldwork placement for an OT, I did not really have the chance to prepare myself before I set foot on the grounds of the first farm. My only preparation had been to visit a youth prison in Bremen, where I had the oppurtunity to talk to two occupational therapists who were experienced in working with this very specific clientele. I bought a few games, took my guitar and boarded the plane to Windhoek, Namibia.

I was **the first occupational therapist who had ever worked for this project** and therefore often had to explain what an OT does. But somehow the social workers there and I found a way to plan how my work could be done. We decided that I would visit the youths on the farms where they lived and stay with them for one or two weeks. This meant that mostly I met just one client at a time, though sometimes there were two or even three or four boys to work with. I met a very widespread spectrum of motivation, interest, fantasy, talent, intelligence, willingness to co-operate, friendliness, (loss of) perspective, aggression, etc. Some of them had been diagnosed with ADHD in the past, some were depressive or had even been suicidal. It was always very intriguing to find out who I had to cope with next.

The main focus of my work was on emotional and psycho-social components. To start with, I always wanted to find out about the interests and abilities of the young people. What did they really like doing and what would they like to do but had never had the chance? Through **creative work**, a few of them really found a way to gain some insight into different aspects of their personality, abilities and skills. It was a real success when two boys who had not talked to each other for a long time suddenly decided to make a film together or when someone whose favourite pastime was watching TV went for a 14 km walk with me. I did other things with my clients, too, such as painting, making collages, making music (I really found some talented drummers, keyboard and guitar players among them). We made films, wrote poems, worked with clay, prepared some interesting meals, baked cakes and played a lot of games. I also talked a lot with the members of the integration families, who often felt overwhelmed by the situation. I informed them about ADHS or told them what I had found out about their integration children.

When I returned to Germany after six months I had the feeling that I had done something very worthwhile. First of all, for myself, because not only had I got to know a very beautiful country and a different culture, I had also learned a lot through my work. Even though I had really struggled hard sometimes to make the therapy move on, there was at least some success with all of the clients. Also, the project gained some new experience by having worked with an occupational therapist.

With my last words I want to encourage you if you are planning something similar but aren't yet sure whether you really want to go through with it – have you really anything to lose?

Daniela Wolter

Doing Further Training: The PNF Vourse in Vallejo, California

How can one combine learning new professional skills, working in a foreign country and getting to know a different culture? One convenient way is to apply to a **postgraduate study programme**. I chose a postgraduate programme in the skill of proprioceptive neuromuscular facilitation (PNF) in the USA. The main reasons to go there were to find out how American physical therapists work, what I could add to my way of working and also how the American health care system functions.

The course is offered in a rehabilitation centre which is part of a private hospital. The patients must have been a member of a certain health plan, provided by specific health care companies, to receive health care service at this rehabilitation centre. Most of the facility's population are adult and neurologically involved, e.g. they suffer from stroke, spinal cord injury and TBI. The rehabilitation centre is organized as a rehabilitation unit for the purpose of providing an integrated, multidisciplinary team approach.

Every year there are three to four courses open for up to twelve physical therapists, who can choose between a three-, six- or nine-month course. I

enrolled on a **three-month course**. The classes were held eight hours daily by different instructors and combined didactic and clinical training of PNF techniques and other rehabilitation procedures as they apply to individualized therapeutic exercise programmes.

Alongside the classroom activities we were given precise responsibilities in terms of patient treatment. The so-called "three-month students" did the **gait treatment**. This included 30-minute individual sessions emphasizing gait and trunk strengthening in a sitting or standing position. All activities took place in a big gym where staff physical therapists, assistants and the course students worked together. There were always supervisors who could assist you or give you advice on any case. Once in a while we were asked to work on weekends, for which we were paid a small salary. These treatments consisted mostly of group and preventative activities. It gave the students the opportunity to work more closely with the staff therapists. Involving the family is a very important part of the rehabilitation centre concept. For this reason we were also in charge of teaching family members, e.g., wheelchair use, self-care activities, how to walk the patient or to perform easy exercises.

It was interesting to experience an intensive PNF training and to get acquainted with rehabilitation procedures. The rehabilitation centre provided a well-organized programme for the students and a **complex rehab** for the patients. I was very often amazed by the intensity of treatment and the patient's will to work hard, as well as by the way the family is involved. Such high motivation may be explained by the fact that the maximum length of admission is only two to three weeks.

Our instructors worked very well with us, we never had to hesitate before asking questions and there was never a feeling of hierarchy. Of course we were aware of being on a course where a specific method was taught and only little room was given to alternatives. However, the manner of communicating with the staff and other health allied professions was always very pleasant and laid back, without losing the seriousness.

The programme was very challenging, but it also left us room to discover American culture and everyday life. We students lived together in furnished rooms that belonged to the hospital. Through this we had the chance to learn from different cultures and to make friends with the students and the staff. Almost every weekend we went on a trip to explore different national parks, beautiful beaches and crazy places, played baseball, and attended several "baby showers".

This postgraduate programme was a very good way for me to go abroad as a physical therapist, but there is a lot to consider and to plan ahead.

Kirstin Lambrecht

Active Vocabulary: Working Abroad

Additional info online

Here is some vocabulary that might be helpful for your discussion. Write down the German equivalents to these words.

- charity = _____
- community-based rehabilitation = _____

- developing country = _____
- embassy = _____
- immigration office = _____
- internship = _____
- professional indemnity insurance = _____
- professional liability = _____
- residence permit = _____
- social insurance = _____
- travel health insurance = _____
- vaccination = _____
- volunteer agency = _____
- work permit = _____

Discussion

Perhaps the three case stories reminded you of your own experiences abroad or described the type of project you are thinking of doing in the future. Or perhaps you did something completely different or have some other dreams about your future adventure abroad.
Get together in a group and talk about your own experiences or ambitions:

- Have you already been abroad yourself?
- Where did you go? Why did you decide to go there?
- How did you spend your time abroad? What did you learn from the experience?

or

- Have you ever been interested in going abroad?
- Where would you want to go? Why would you want to go there?
- How would you want to spend your time abroad? What would you expect to gain from the experience?

Note

As far as English-speaking countries are concerned, some important information on studying abroad is found in ▶ Unit 6 and on working on a regular basis as a therapist in ▶ Units 7.2 and 7.3.

Group Activity

Choose a country and decide on the type of project you want to do, e.g. going to university, doing a further education course, working for an international relief and development organization, etc.
Make a mind map of "Things You Should Know Before You Go" – and how to find out about them – as well as a checklist for all the necessary preparation.
When you have finished, compare your answers with those of the other teams.

Note

National as well as international professional associations for therapists give you information on a wide range of countries. Check out their websites as a possible starting point.

7.2 State Registration and Professional Associations

The Process of Registration in the United Kingdom and the Republic of Ireland

In order to work as an AHP in countries such as Australia, the USA, the Republic of Ireland and the United Kingdom, the professional is required to be **registered with a professional registration body** to obtain clearance to practise within the relevant profession.

In the United Kingdom, for example, each health professional must be state-registered with the **Health Professions Council** (**HPC**). The Health Professions Council assesses each of its members for their fitness to practise. The HPC issues a **certificate of membership** to successful membership applicants. This membership has to be renewed every two years. The HPC publishes the professional details of each member on the HPC webpage, verifiable by the public. A **registration with the HPC** for AHPs is **mandatory** for all public sector health care jobs and is more and more often requested for jobs in the private sector as well. In the UK, a **registration with the relevant professional association**, such as the Chartered Society for Physiotherapists (CSP), for instance, **is optional**.

It is advisable for each AHP looking for work in a foreign country to contact his or her relevant professional association well in advance to obtain as much information as possible regarding **registration procedures**. This is because the registration process can be long and tedious and in some cases it may take up to one year until all the relevant documents are available and translated.

Note

Implementation of European Directive 2005/36/EC for Health and Social Care Professions in the UK / The European Qualifications (Health and Social Care Professions) Regulations 2007
European Directive 2005/36/EC was adopted on 7 September 2005 and all member states must transpose it into domestic law by October 2007, when it will come into force. "The intention behind the directive is to make it easier for qualified professionals (architects, accountants, teachers, health professionals, etc.) to practise their professions in European countries other than their own, with a minimum of red tape but with due safeguards for public health and safety and consumer protection. It provides for the mutual recognition of diplomas, certificates and other evidence of formal qualifications in order to assist the free movement of professionals throughout the EU."
According to the Department of Health consultation paper (May 2007) the implementation of European Directive 2005/36/EC will lead to the recognition of allied health professionals from EU member states in the UK on the following basis:

"Migrants still have the right to have their qualifications recognized in the host member state. However, their **training is considered on a case-by-case basis and regulatory authorities can require migrants to choose between taking an aptitude test, or working through an adaptation period before registration**. The onus for checking migrants' training standards falls firmly on the regulatory authorities of the host member states."
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_074933

Additional info online

Active Vocabulary: State Registration

What do these words used in the above text mean in German?

- adaptation period = _____
- certificate of membership = _____
- clearance to practice = _____
- directive = _____
- fitness to practice = _____
- implementation = _____
- mandatory = _____
- mutual recognition = _____
- red tape = _____
- registration body = _____
- state-registered = _____
- verifiable = _____

Registration Requirements in Canada: CASLPA & CASLPO

The following words are missing from the text below. Fill in the gaps by adding the appropriate verb endings where necessary. The first one has already been done for you as an example.

abbreviation	to accumulate	body
college	complaints	consumers
designation	employment	exam
fees	in accordance with	licence
malpractice	mentorship programme	minimum
operable	~~professional association~~	professional association
professional initials	to protect	public interest
reciprocity	re-registration	

Audiologists (AUD) and speech-language pathologists (SLP) in Canada are strongly encouraged to become members of a provincial/territorial professional association (1) – e.g., the British Columbia Association of Speech-Language Pathologists and Audiologists (BCASLPA) – and/or the national _____ (2) – the Canadian Association of Speech-Language

Pathologists and Audiologists (CASLPA) – when seeking _____ (3) or once employed. In some cases having CASLPA membership automatically means also having membership with a provincial/territorial _____ _____ (4) like the BCASLPA. These professional associations provide an opportunity for audiology and speech-language pathology needs, interests and developments to be supported with the interest of _____ (5) at the forefront of all professional activity. By becoming a member of CASLPA employers, colleagues and consumers can be assured that his or her AUD or SLP is "certified". All members of CASLPA will have passed a comprehensive _____ _____ (6) prior to certification. The letter (C) typed after the name, degree and _____ (7) of an AUD or SLP indicates the "certified" _____(8), e.g., Candy Green, M.Sc., SLP (C). Members wanting to maintain their certification status must pay yearly _____ _____ (9) and, most importantly, submit to CASLPA on a yearly basis evidence of having obtained continuing education equivalents (CEEs). CASLPA requires that all certified members _____ (10) a total of 45 CEEs within three years.

Attention should be made that the (C) designated to CASLPA members be not confused with the triple CCCs of ASHA's (American Speech and Hearing Association) members. _____ (11) between CASLPA and ASHA, however, exists; that is, members with their CCCs are able to work in Canada and vice versa.

CASLPO is the College of Speech-Language Pathologists and Audiologists of Ontario. Its purpose is to "regulate the professions, in the _____ _____(12), and to govern its members _____ (13) the Regulated Health Professions Act, 1991, the Audiology and Speech-Language Pathology Act, 1991, and the regulations and by-laws adopted by the College". The college _____ (14) consumers by assuring them that their professionals have no less than the _____ (15) knowledge and skill set required to provide "best practice"; high quality service is assured. Formal _____ (16) from consumers can be directed to CASLPO who would thereby investigate any allegation. CASLPO members risk losing their _____ (17) to practise if _____ (18) is determined.

The _____ (19) "Reg. CASLPO" indicates those members who are designated as being registered with the college, e.g., Sophia Blank, M. Sc., Reg. CASLPO. At present a _____ (20) for AUDs and SLPs exists only in the province of Ontario in which CASLPO membership is mandatory. Some other Canadian provinces/territories are in the process of establishing their own colleges, however, none are yet _____ (21). CASLPO membership is obtained only after new university graduates or new employees to Ontario have completed a six-month _____

(22) under the auspices of a fellow AUD or SLP in their first place of employment. Yearly _____ (23) with fee payment, self-assessment and possibly peer assessment, and submission of continuing education equivalents is additionally expected.

Questions

1. What is the difference between a registration board and a professional association?
2. Where would you need to get registered as a therapist in the United Kingdom, in the Republic of Ireland and in Canada?

Exercise

1. Where would you need to get registered as an OT, PT or SLT in other English-speaking countries, e.g. South Africa, Australia, New Zealand and the USA? See if you can find out on the internet. What are the registration requirements for foreign applicants in these countries for your own profession? Do some research to find out.
2. Which professional associations exist for OT, PT and SLT in other English-speaking countries and what are their responsibilities? Do some research on the web concerning your own profession and prepare a presentation for your fellow students.

7.3 The Job Application Process in the United Kingdom and the Republic of Ireland

Job Description

New posts need to be **advertised** (in newspapers and on the internet). The job description for allied health posts lists the **essential criteria** the applicant has to meet, such as length of previous job experience, relevant university degree and registration with relevant professional registration board. It also lists required competences expected of the applicant for the post.

Examples of **competences** expected from allied health professionals (taken from the North Eastern Health Board – Ref. 2004/ 137, Republic of Ireland):

1. **Planning and managing resources** – the therapist plans activities and coordinates resources to ensure value for money and maximum benefit for the organization. He or she sets realistic time-frames for the completion of tasks and monitors progress to ensure that deadlines are met. He or she prioritizes tasks appropriately and delegates to ensure efficiencies. He or she works in a structured and planned manner and ensures information is kept up to date.

2. **Evaluating information and judging situations** – the therapist relies on professional expertise and management experience to understand and evaluate problems. He or she gathers information from a variety of sources before evaluating the benefits and consequences of decisions. He or she demonstrates sound practical judgement and decisiveness.

3. **Assuring high standards in the service of today** – the therapist sets professional standards and establishes procedures to ensure they are maintained. He or she cooperates with accreditation procedures. He or she regularly monitors the quality of work and strives to ensure full compliance with legal, professional and safety standards.

4. **Maintaining composure and quality of working life** – the therapist maintains a calm and controlled style across all situations. He or she is flexible during challenging times and perseveres despite setbacks and the pressures of the role. He or she takes responsibility for his or her own health, well-being and work/life balance.

Application Form

In order to apply for the position of a physiotherapist, occupational therapist or speech and language therapist in the United Kingdom or the Republic of Ireland, the applicant has to follow certain steps. Firstly, he or she will have to **request by telephone or letter a job application form**, which will be sent out to each applicant. This job application form usually contains **three sections**: **personal details**, **academic record** (school education, university education and in some cases degree achieved) and **employment record** (work experience pre and post graduate). In many cases there is a **fourth section** available where the applicant has the opportunity to state why he or she is suitable for the position. It is necessary to provide at least two **references**, which would usually be given by former employers or university instructors. In addition to the application form each applicant should receive a **job description** that briefly outlines the purpose and objectives of the post and in some cases remuneration details and reporting relationships.

The following shows the content of a job application form (Republic of Ireland).

APPLICATION FOR EMPLOYMENT

Please complete in black ink/biro/typescript (to aid photocopying)

Post/Job Title	Post No.
Department	Closing Date

Disabled applicants will be guaranteed an interview if they show they meet the essential criteria for the post. Please tick if you are applying on this basis ☐

Tick here if this is a Job Share application ☐

Personal Details

Last Name:	First Name(s):	
Address:		
		Post Code:
Telephone numbers:	Daytime:	Home:
E-mail:		Mobile:

General Education

From	To	Schools, Colleges, Universities attended including part-time	Qualifications gained (give overall subject and level)	Grade

Professional qualifications and registration (PIN numbers where relevant) including membership of professional bodies

Qualifications	Professional body- Registration/PIN number	Grade

Job Title				Grade	
Salary/Wage	£ p.a./week	Additional Payments (if appropriate)		Full time ☐ Part time ☐ If part time, hours worked:	
Date Appointed		Date employment ended if applicable		Notice Required	
Brief description of duties and responsibilities (including reason for leaving if last employment)					

Have you worked for this organisation previously? YES/NO
If yes please give details below.
Previous employment in the last 15 years (most recent first)

Name and address of employer	Job Title	From mth/yr	To mth/yr	Reason for leaving

Relevant experience in support of application
Please give an account of any relevant experience with reasons for applying for this post, including details of skills, abilities and any training courses you may have attended. Remember to include any relevant experience such as community or voluntary work, looking after elderly people or children, etc. (Continue on separate sheet if necessary).

References: From two persons willing to give you a reference, one whom must be your present or most recent employer (neither should be a relative).

Present or most recent employer	
1. Name: Post held: Address: Telephone:	2. Name: Post held: Address: Telephone:
May this referee be contacted prior to interview? YES/NO	May this referee be contacted prior to interview? YES/NO

Are you related to any member of staff in this Trust? YES/NO
If yes, please give details

Do you require a work permit or special permission to work in the United Kingdom? YES/NO

Do you possess a current, full driving licence? YES/NO

Rehabilitation of Offenders Act 1974

Because of the nature of the work concerned, this post is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974. You are not entitled to withhold information about convictions which for other purposes are "spent" under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation to your application for this post.

Have you at any time received a Court conviction? YES/NO
If yes, please give details:- *(including driving convictions)*

Failure to disclose all convictions, including "spent" ones, will lead to your application form being disqualified, or if you are appointed to your dismissal.

Declaration: I confirm that the information given on this form is, to the best of my knowledge, true and complete. Any false statement may be sufficient case for rejection or, if employed, dismissal.

Date ..... Signature .....

PLEASE RETURN COMPLETED APPLICATION FORM AND EQUAL OPPORTUNITIES MONITORING FORM TO:

Competence-Based Essays

The four competences listed in the text above (pp. 192–193) are examples of themes of **competence-based essays** that must be written in preparation for a Basic Grade therapist job interview in the **Republic of Ireland**. These four essays (500 words each) are **submitted before the job interview**.

Example: Competence **Communication Skills:** "Be able to adapt your communication style to particular situations and audiences….. Be able to produce clear and concise written information."

a) The unit I was attached to was responsible for producing a management report and supporting oral presentation for several large clients, some with significant problems and issues to report. In some cases the management report was publicly available and was subject to a great deal of scrutiny. A new style/format of management letter needed to be developed for my clients, as many of the clients were complaining that the letters were too long and difficult to read.

b) I was tasked with developing a new style of management letter for the clients. I had to meet stringent quality requirements/criteria whilst addressing the need to reduce its size. Following consultation, mainly over the phone and face-to-face, with the majority of our clients, I realised that a summarised report format with a better visual and more interactive presentation was the answer. I developed a format for a summarised report, reducing the average length from 40 pages to just 10. I achieved this through careful editing of information and increased use of graphs etc. I then developed a more focused presentation to clients and included more graphical displays and incorporated short presentations by colleagues directly involved in producing the work. During the presentations I encouraged clients to ask questions and develop their understanding of the issues at hand.

c) The summarised management report and improved presentations were seen as a success by the clients, who without exception, in responding to an evaluation survey, found the new format/style better than the previous, and all requested that the revised system should be continued.

Source: *The Interview Guide Ireland*. Republic of Ireland/Health Service Executive (ed.). 2006

Exercise

Imagine you were to apply for this kind of post. Give an example of a situation in which you demonstrated your ability to: 1) plan and manage resources, 2) evaluate information and judge situations, 3) assure high service standards or 4) maintain composure and quality of working life. In doing so, remember to provide information on:

- the nature of the task, the problem or objective you encountered or dealt with
- what you actually did and how you demonstrated the skill or quality
- the outcome or result of the situation and your estimate of the proportion of credit you can claim for the outcome

Job Interview

If the applicant meets the essential requirements as outlined in the job description he or she will be sent an appointment for a job interview. Job interviews for health profession posts are usually **competence-based interviews**, which means that the applicant will compete with the other applicants and will be asked **clinical questions in relation to the competence profile**, i.e. the level of skills and clinical knowledge as expected from a successful candidate for the available post. The job interview for a junior or basic grade position is usually held by a **panel** of three job interviewers (one of them would normally be the OT, PT or SLT line manager); interviews for higher positions such as Senior I grades or equivalent can sometimes be held by a panel of four interviewers. The interviewers ask the candidate competence-based questions and he or she will score marks for the answers given in each section of the interview.

The applicant will be informed a few weeks after the interview whether he or she was successful, unsuccessful or has been short-listed. All **official documents** such as school-leaving results, degree certificates, professional postgraduate documents (courses, further university studies), state registration and professional association membership are presented once the applicant has been offered the post. Once all administrative aspects are dealt with, the successful applicant will be sent a **contract** and **job description**. It is common to write a **letter of acceptance** to the employer or the health board to state that he or she accepts the offer and agrees to the **professional duties** outlined in the job description.

Shortlisting

In some cases unsuccessful candidates, who were not first choice, but still very good in their interview can be put on a shortlist, which means that they **might receive the next available position equivalent to the one for which they were initially interviewed**. In this case they do not have to attend another interview. Applicants should read the job description carefully, as some posts are advertised as **shortlisting positions**. This procedure is carried out by hospitals to have good staff available when needed and for personnel planning purposes.

References

The references required for job interviews are usually issued by **former or current OT, PT or SLT managers** or **university lecturers**. In general the referee should have known the applicant for more than three years and should not be related to the applicant. On the job application form the applicant will provide the **contact details** of two referees, who will then be

contacted and sent out a reference form by the possible future employer. This process is independent from the actual applicant, who will never see the references. In such a reference the referee is usually asked to **comment on the applicant's reliability, integrity, working behaviour and suitability for the post:** "Do you consider the applicant suitable for the position of…?". The reference also leaves the option for the referee to give a brief subjective **personal comment** on the applicant.

Note

In Canada, you are often required to provide references from three referees, typically not all in a management position. One may be your manager but the others may be your OT, PT or SLT colleague(s) and/or the third may be another type of team member (e.g., a social worker).

7 **Additional info online**

Active Vocabulary: Job Application

Please match the English expressions with their German equivalents. The first one has already been done for you as an example.

1. applicant	A. Absage
2. to apply for a job as…	B. ArbeitgeberIn
3. certificate	C. Arbeitsvertrag
4. certificate of good conduct	D. Ausschuss
5. competence	E. Begleitschreiben (hier: Bewerbungsbrief)
6. contract	F. Berufsausbildung
7. covering letter (BE) / cover letter (AE)	G. Berufserfahrung
8. curriculum vitae (= CV) (BE) / résumé *or* resume (AE)	H. BewerberIn
9. document	I. Bewerbung
10. employer	J. Bewerbungsformular
11. employment offer	K. Bewerbungsgespräch
12. job advert(isement)	L. Dokument
13. (job) application	M. Empfehlungsschreiben
14. (job) application form	N. Entgelt, Bezahlung
15. job description	O. freie Stelle
16. job interview	P. Führungszeugnis
17. letter of acceptance	Q. Stellenangebot, Jobangebot
18. letter of decline	R. Kompetenz
19. letter of recommendation	S. Lebenslauf
20. panel	T. Position, Stelle

21. position, post	U. Referenz
22. professional experience, job experience, work experience	V. sich als … bewerben
23. professional training, professional education	W. Stellenanzeige
24. reference	X. Stellenbeschreibung
25. remuneration	Y. Urkunde
26. vacancy	Z. Zusage

7.4 Writing a Curriculum Vitae (CV)/Résumé

As explained in chapter 7.3, employers in the **United Kingdom** and the **Republic of Ireland** ask applicants to complete an application form. You may still be asked to submit a CV in the UK and the Republic of Ireland, though do not send in a CV and a covering letter unless this has been specifically requested.

In the **USA** and **Canada**, it is customary to send a résumé and a covering letter, though, when applying for a new post.

The Chartered Society of Physiotherapists lists the following **points to consider when compiling a CV:**

- use good quality, unlined A4 size paper
- type the information, spacing sections well, so it does not look cluttered
- check your spelling
- keep your CV to no more than two pages
- ensure your CV is completely up to date
- ensure that any gaps in your career history or education are explained. If necessary, write "career break" and a brief reason for the break so an employer is not left wondering.

http://www.csp.org.uk/director/careersandlearning/physiotherapyjobs/cvwriting.cfm

Sections/Parts of a CV/Résumé

personal details
- full name, address, phone number and email

professional experience
- job title, name of employer and a brief summary of key duties and responsibilities

education and training
- for academic qualifications, the examinations passed with their grades need to be listed
- including continuing professional development activities if applicable to the post you are applying for

interests and achievements
(only those with a direct impact on the advertised post: e.g. membership of clinical interest groups, involvement in professional committees, external groups you belong to)

references
- list the names (including academic and professional titles) and addresses (ideally work not private addresses) of those who are willing to comment on your professional experience and personal qualities
- alternatively you may indicate in your cover letter that references are available on request

Some Peculiarities of CV-/Résumé-Writing:

- unless specifically stated, no photo is required
- personal details do not include information on date of birth, gender and marital status
- under each heading you list all the information in reverse chronology, i.e. you start with the most recent events and then go back in time
- include school qualifications if relevant to your professional role, otherwise commence from post-compulsory education
- you do not enclose any work testimonials
- give a brief summary of your key duties and responsibilities
- you only list the names of referees but do not enclose any references

Example of a CV/Résumé:

Here is an example of a résumé written for a job application in the United States:

Résumé

Barbara Jean White
979 E. Jackson St.
Forest Grove, Oregon 97123
U.S.A.
Phone: (503) 357-1348
Email: bjwhite@internet.com

OBJECTIVE:
A fulfilling career helping children gain independence that will continue to challenge my knowledge and skills on a professional and personal level.

EDUCATION:

1982	Certification exam: became a certified occupational therapist, registered (OTR) after passing the National Board for Certification in Occupational Therapy.
1981-1982	Affiliations: Alaska Psychiatric Institute, Seward Elementary School for handicapped children, Good Samaritan Rehabilitation Hospital.
1977-1981	University of Puget Sound, Tacoma, Washington Degree: BS in occupational therapy with honours
1973-1977	Hillsboro Union High School High school diploma with honours
1965-1973	Peter Brown Grade School and J. W. Poynter Junior High School

PROFESSIONAL EXPERIENCE:

Dec. 1987-	Youth and Family Therapeutic Counselling Centre, Portland, Oregon Paediatric diagnostics and therapy for children with learning disorders, perceptual motor dysfunctions, sensory processing disorders; parent counselling
1985-1987	Regional Counselling Centre for Behavioural Disorders, Bend, Oregon Day programme for children with behavioural disorders
1984-1985	Rehabilitation Centre, Valens, Switzerland Neurological adult rehabilitation
1983-1984	Mental Health Services of Yakima, Yakima, Washington Outpatient programme development and treatment for children and adults

CONTINUING EDUCATION:

2000	Sensory integration in the new millennium, Prof. Charlotte Brasic Royeen, Ph.D., OTR, Portland, Oregon
1999	Symposium: Sensory integration and autism – tool chest for parents and teachers, Diana Henry, MAOT, Munich, Germany
1995	Luria's learning and memory diagnostics and therapy, Dr. J. Donczik, Seattle, Washington
1994	Diagnostics and treatment for infants and toddlers, Dr. Georgia DeGangi, Denver, Colorado
1994	Left-handedness: Research, diagnostics and treatment, Dr. Barbara Sattler, London, England

I have been a member of the American Occupational Therapy Association (AOTA) since 1983 and a supporting member of the Society for Sensory Integration International, London, England since 1990.

Barbara Jean White, OTR/L 02/18/2003

References available upon request

Exercise

Write your own CV. Here is some useful vocabulary:

Active Vocabulary: CV/Résumé Writing

achievements	Leistungen
additional skills	weitere Kenntnisse
career objective	Berufsziel
citizenship	Staatsangehörigkeit
clinical placement	Praktikum im Rahmen der Berufsausbildung (OT, PT, SLT)
duties and responsibilities	Aufgaben
education	Ausbildung
experience	Erfahrung
expertise	Fachwissen, fachliche Kompetenz
extra-curricular activities	freiwillige Aktivitäten an der Hochschule
fieldwork placement	Praktikum im Rahmen des Studiums
in-depth knowledge	vertiefte Kenntnisse
newly qualified	neu im Beruf (d. h. Berufsanfänger)
personal details	persönliche Daten
prerequisite	Voraussetzung
qualifications	Qualifikationen
requirement	Anforderung
responsibility	Verantwortung
skills	Fähigkeiten, Fertigkeiten
task	Aufgabe
work load	Arbeitspensum

7.5 Writing a Covering Letter for a Job Application

In **North America** application forms are not typically mailed to applicants. Rather, when the individual professional finds out about a job, he or she may make inquiries and then writes a **cover letter with attached résumé**. These both are then sent to the place of employment – one copy directly to Human Resources and a second to the OT, PT or SLT department (depending on the model of management the respective facility has adopted to the head of department, the professional practice leader or the programme manager).

Here is a template for an American-style cover letter:

Your name
Mailing address
City, state, and zip
Telephone number(s)
Email address

Today's date

Recipient's name
Professional title
Organization name
Mailing address
City, state and zip

Dear Mr. …, / Dear Ms. …, / Dear Dr. …,
Alternatively, if no name is given:
Dear Sir or Madam,
Dear Health Care Professional,
Dear Director of Personnel,

Try to start your letter with a statement that establishes a connection with your reader. Briefly say what job you are applying for.

The mid-section of your letter should consist of one or two short paragraphs that make relevant points about your qualifications. Do not simply summarize your résumé! You may incorporate a column or bullet point format here to clearly arrange several points.

Your last paragraph should initiate action by explaining what you will do next (e.g., call the employer) or suggest to the reader to contact you to set up an interview. Close by saying "thank you."

Sincerely yours,
Your handwritten signature
Your name and professional initials (typed)

Enclosure: résumé

Example of a Covering Letter

Here is an example of a **covering letter** for an SLT position from Canada.

Jennifer Walker
9-120 Charles Street
Hamilton, ON L8P 3E5

Human Resources
Toronto Rehab, University Centre
550 University Avenue
Toronto, ON M5G 2A2

July 23rd, 2007

RE: SPEECH-LANGUAGE PATHOLOGIST POSITION

Dear Sir or Madam,

I have recently become aware of the Speech-Language Pathologist (SLP) positions available with Toronto Rehab. I am submitting this letter and attached résumé in order to be considered for the positions within the neuro rehabilitation and/or complex continuing care programmes. I am a registered member of the College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO) in good standing and a certified member of the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA).

I strongly believe that my clinical experience obtained with the neuroscience programme at Hamilton Health Sciences has afforded me ample opportunity to develop the skills that you are searching for in your new employee. I have worked extensively with adults with acute acquired brain injuries in addition to individuals with spinal cord, other orthopaedic, and burn injuries. In my role as an SLP, I have been responsible for the assessment and management of swallowing and communication disorders in these populations at both the critical (i.e., ICU) and acute stages of recovery. My experience with swallowing disorders involves conducting both bedside swallowing examinations and videofluoroscopic swallowing studies. In the area of communication, I am experienced in the assessment and management of motor speech, language and cognitive-communication disorders. My role as an SLP in acute care hospital also has included early education and counselling to clients and their families about the recovery stages of brain injury, educating members of the health care team regarding communication and swallowing disorders, attending family meetings, developing treatment plans for insurance companies and rehabilitation providers, and discharge planning.

Clinical growth within the area of adult rehabilitation is of particular importance to me. Opportunities for the advancement of clinical practice, education and research are also of importance to me. It is for these reasons that I take particular interest in finding employment within your facility.

Thank you in advance for taking the time to consider my application. I would be happy to discuss further details of my experience with you in a personal interview.

Sincerely,

Jennifer Walker
Jennifer Walker,
M.Sc., SLP (C) Reg. CASLPO
Speech-Language Pathologist

Enclosures

In the USA, application forms and interview procedures vary according to the job situations. Application instructions and assistance are often found on the individual web sites.

Examples of Job Adverts

Here are some typical job offers as examples:

OCCUPATIONAL THERAPISTS NEEDED!

The Southern County Special Education Services located in Lowlands Park, WA has immediate openings for full-time and part-time occupational therapists to work with school-age children in public school settings. Great salary, benefits, and working school calendar.

Call today for application at 123-456-7890; fax résumé to 123-456-9876; or e-mail info@scousped.usb Visit our Web site **to apply online**: www.scousped.usb.

REHABILITATION HOSPITAL OF NEW LAKES

OT and COTA positions available for inpatient and outpatient settings. New Graduates, Senior Level Therapists or Clinical Specialists are welcome to apply!

Ideal therapists would possess:

- specialty certification or training in neuro and brain injury
- strong clinical skills working with amputee, stroke and spinal cord injury patients, driver's rehab and low vision background
- Benefits include liability insurance, major medical insurance, continuing education, flexible hours, paid vacation and professional license reimbursement.

If interested, please forward your résumé today to:
Rehabilitation Hospital of New Lakes
999 Medical Drive, Waterview, WC 98765

We are currently seeking professionals for the following position(s):

Speech-Language Pathologist
Full-time & Part-time (Permanent) Positions

We provide a variety of service delivery options to families and children with special health needs in communities. Children's C.A.R.E. services is presently recruiting 2 speech-language pathologists for Whitewater and area.

The successful candidate will be responsible for the provision of assessment and intervention services to pre-school and school-age children with a variety of delays and disorders. Children's C.A.R.E. services are comprised of a team of rehabilitation professionals which value a child-centred/family focused approach to service delivery.

Required Qualifications: Master's degree in Speech-Language Pathology. Hanen certification and experience in working with pre-school and school-age children would be considered an asset. Candidates will need to be licensed by the Alberta College of Speech Language Pathologists and Audiologists.

New grads are provided with opportunities for CFY certification or mentorship program.

To learn more about how you can enjoy a great lifestyle as part of a great team, call:

Marjorie McCornickle, 1-757-323-3671 or (403) 345-5346, fax your résumé to (403) 328-5066 or email to: mmccornickle@internet.ca

Orange County Department of Personnel Services
Physical Therapist I (Department of Community Health)
Recruitment #05-1580-0027
Salary: I: $4,485-$5,453 Monthly
Date Opened: 7/17/2008 8:00:00 a.m.
Filing Deadline: Continuous

Orange County's Department of Community Health is seeking Physical Therapists to provide rehabilitative therapy to children within the California Children's Services Division. Physical Therapists will conduct home and or school visits throughout Orange County to provide therapy, instruction to parents and caregivers in home exercise programs, and may assist in the training of staff and students. The current vacancies require candidates to provide their own transportation and insurance liability limits.

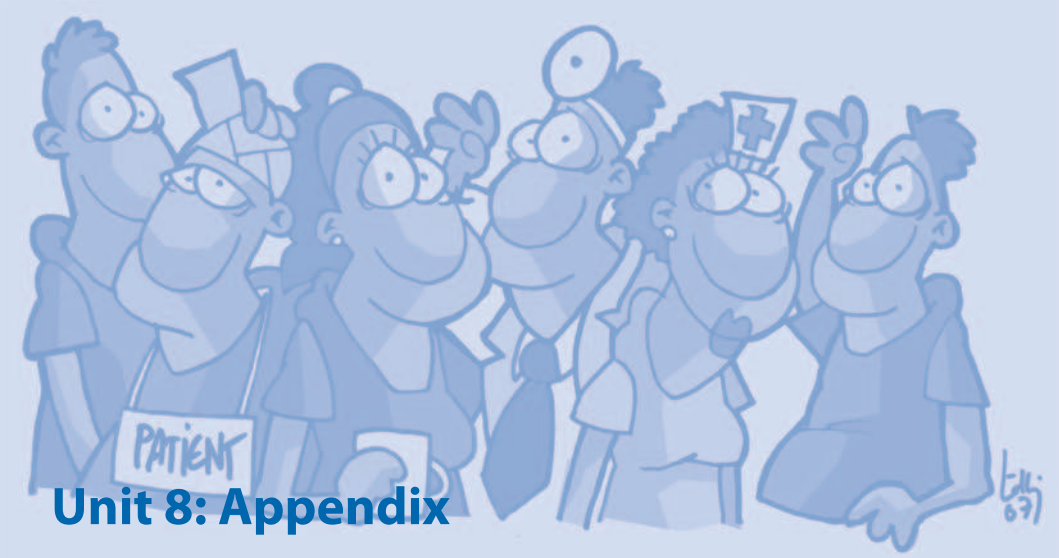
Minimum qualifications:
Registration: Current California Licensure as a Physical Therapist with the State of California, Department of Consumer Affairs Physical Therapy Board of California.

Samples of duties:
- Consults with doctors and/or supervisors to determine treatment plan.
- Plans and performs physical therapy for neurologically and physically disabled clients, including soft tissue mobilization, joint mobilization, gait training and muscle reeducation through corrective exercises.
- Schedules and administers evaluations at MTU, home assessments for equipment needs, and school consults to establish school directed activities such as standing programmes.
- Administers tests such as manual muscle tests, joint range of motion, reflex testing, postural assessment, gait analysis, and functional mobility.
- May assist in training therapy aides in treatment of clients.
- Instructs clients, family members, and caregivers regarding home exercise programs and equipment needs.
- Observes, evaluates and records client's treatment, reactions, and progress and reports changes to doctor.
- Counsels and refers clients to vocational rehabilitation programs for further testing and training.

How to apply:
Online: www.jobaps.internet.com
By mail or in person: Department of Personnel Services
2220 Santa Ana Blvd, 14th Floor
Santa Ana, CA 92701

Exercise

Choose one of the above job offers and write a covering letter in reply.



Unit 8: Appendix

8.1 Abbreviation List

abbreviation	meaning
°	degree
“	inch
‘	feet
↑	increase(d)
↓	decrease(d)
#	fracture
Ø	no
(A)	assisted, assistance
a	before
A/A	as above
AAC	augmentative and alternative communication
AAE	activc assistive exercise
AAROM	active assistive range of motion
abd *or* ABD	abduction
ABG	arterial blood gas
ABR	absolute bed rest
AC	before meals
ACBT	active cycle breathing technique
Acc.	accessory
ACL	anterior cruciate ligament
ACT	American college test
AD	assistive device; admitting diagnosis
add *or* ADD	adduction
ADD	attention deficit disorder
ADHD	attention deficit hyperactivity disorder
ADL	activities of daily living
ad lib	as desired
A/E *or* AE	air entry; above elbow
A&E	Accident & Emergency
afeb.	afebrile
A.Fib. *or* a.fib.	atrial fibrillation
AFO	ankle foot orthosis
AHP	allied health profession, allied health professional
AJ	ankle jerk
A/K *or* AK	above knee
AKA	above knee amputation, above the knee amputee
ALD	assistive listening device
ALOS	average length of stay
ALSR	assessment of living skills and resources
a.m. *or* AM *or* am	morning, ante meridiem (before noon)
amb *or* AMB	ambulation
AMP	amputee
ant. *or* ANT	anterior
AP	attending physician
APN	advanced practice nurse
approx	approximately
AROM	active range of motion
ART	active resistive training
artic.	articulation
AS	Asperger Syndrome
as tol.	as tolerated
ASAP	as soon as possible
ASROM	assistive range of motion
ass.	assistance
AT	assistive technology
AUD	audiology
Ax	assessment
(B) *or* B	both, bilateral
BADL	basic activities of daily living
BICS	basic interpersonal communication skills
b.i.d. *or* BID *or* bid	twice a day (bis in die)
BKA	below knee amputee; below-knee amputation
Bl	blood
BP	blood pressure
bpm	beats per minute
BS	breath sounds
BS *or* BSc	Bachelor of Science
C	coordination
CBR	community-based rehabilitation
CCU	coronary care unit
CEE	continuing education equivalents
CNT	could not test
c/o	complains of
coord.	coordination
COPD	chronic obstructive pulmonary disease
COTA	certified occupational therapy assistant
CPD	continuous professional development
CPM	continuous passive motion
CPTA	certified physical therapy assistant
crani.	craniotomy
CV	Curriculum Vitae
CVA	cerebrovascular accident
c/w	consistent with

Cx	cervical
CXR	chest X-ray
D	divorced
DADL	domestic activities of daily living
DAT	diet as tolerated
DBE	deep breathing exercises; dual bilingual education
D/C *or* d/c	discharge; discontinue
DF	dorsiflexion
DHS	dynamic hip screw
DME	durable medical equipment
DNA	did not attend
D.O.	Doctor of Osteopathy
DOA	date of admission
DOB	date of birth
DOD	date of discharge
doff	take off clothing
DOI	date of injury
don	put on clothing
DRS	disability rating scale
DVT	deep vein thrombosis
DW	discussed with
Dx *or* DX	diagnosis
ē	with
EC	elbow crutches
ECU	environmental control unit
ENT	ear, nose, and throat
e.o.d.	every other day
ER	emergency room
ET *or* ETT	endotracheal tube
Ex	exercise
F	Fahrenheit; female
F(A)ROM	full (active) range of motion
FAS	functional assessment of swallowing
f/c	facilitated communication
FET	forced expiration technique
FHx	family history
FIM	functional independence measure
FLEX	flexion
FROM	full range of motion
ft	foot, feet
f/u	follow-up
FWB	full weight bearing
FWP	fieldwork placement
Fx	fracture
g	grade
GCS	Glasgow Coma Score
GCSE	General Certificate of Secondary Education
G.H.	general health
GI	gastrointestinal
GP	general practitioner
GPA	grade point average
GRBAS	hoarse voice scale: overall grade, rough, breathy, asthenic, strained
GRE	graduate records examination
GYN	gynecology
H/A	headache
HCA	health care assistant
HCR	home care representative
HDU	high-dependency unit
HEP	home exercise program(me)
HFA	high functioning autism
HMO	health maintenance organization
HOB	head of bed
HPC	Health Professions Council
HxPC	history patient case
Hr	hour
HV	home visit
Hx *or* HX	history
IADL	instrumental activities of daily living
IALP	International Association of Logopedics and Phoniatrics
IC	interest checklist
ICB	intracranial bleed
ICU	intensive care unit
IEP	individualized education plan
in	inch(es)
INR	international normalized ratio
I/P *or* IP	inpatient
IPA	International Phonetic Alphabet
IRQ	inner range quadriceps
ISQ	in status quo
ITU	industrial therapy unit
IV *or* I.V.	intravenous
JND	just noticeable difference
JROM	joint range of motion
jt	joint
kn	knee
(L) *or* L	left
L base	base of left lung
lat	lateral
lb	pound(s)
LBP	low back pain
LD	learning disabilities; learning disabled
LL	lower limb; lower lobe
LLL	lower left limb; lower left lobe

LOB	loss of balance
LOC	loss of consciousness
LOS	length of stay
LOT	licensed occupational therapist
LPN	licensed practical nurse
LPR	laryngopharyngeal reflux
LPT	licensed physical therapist
LRE	least restrictive environment
LRL	lower right limb; lower right lobe
LSF	left side flexion
LTC	long-term care
LTG	long-term goal
LUL	left upper limb; left upper lobe
L&W	living and well
Lx	lumbar
M	male; married
Meds.	medications
M.D.	Doctor of Medicine
MFT	muscle function test
MH	mental health
MI	myocardial infarction
MLT	mean length speaking turn
MLU	mean length of utterance
MMSE	mini-mental status exam
mo.	month
mod.	moderate
MRI	magnetic resonance imaging
MRSA	methicillin-resistant staphylococcus aureus
MS	Master of Science
ms.	muscle
MSc	Master of Science
MTA	medical technology assessment
MTU	musculo-tendinous unit
MVC	motor vehicle collision
mvt.	movement
N	normal
N/A	not applicable
NAD	no abnormalities detected
NFAR	no further action required
NG	nasogastric (tube)
NHS	National Health Service
NICU	neonatal intensive care unit
NKDA	no known drug allergy
NLD	nonverbal learning disorder
noc. *or* noc	night
NOK	next of kin
NP	nurse practitioner
NP	nasal prongs
NPO	nothing by mouth (non per os)
N/S	nursing staff
NWB	non-weight bearing
O	oriented
O/A	on auscultation
OB	obstetrics
OBGYN	obstetrics and gynaecology
OBS	observation
ODQ	on direct questioning
OE *or* O/E	on examination
OH	occupational history
OOB	out of bed
OP	outpatient
OQ	Occupational Questionnaire
ORIF	open reduction internal fixation
OT	occupational therapy; occupational therapist
OTA	occupational therapy assistant
OTL	occupational therapist, licensed
OTR	occupational therapist, registered
OTR/L	occupational therapist, registered/licensed
O x 4	oriented to time, place, person, situation
oz	ounce
p	pain
P	power
p̄	after
PA	physician assistant
P/AAROM	passive/active assisted range of motion
PADL	personal activities of daily living
PaO_2	arterial oxygen pressure
PARA	paraplegia
p.c.	after meals (post cibum)
P/C	patient case
PCL	posterior cruciate ligament
PCN	primary care nurse
PCS	picture communication symbols
PCT	Primary Care Trust
PDD	pervasive developmental disorder
PE	physical examination, pulmonary embolus
PEP	positive expiratory pressure
PF	plantar flexion
Ph.D.	Doctor of Philosophy (USA)

PICA	posterior inferior cerebellar artery
PID	prolapsed intervertebral disc
p.m. *or* PM *or* pm	afternoon
PMHx	past medical history
PNF	proprioceptive neuromuscular facilitation
POA	power of attorney
PPO	preferred provider organization
PRE	progressive resistive exercise
pro *or* PRO	pronation
PROM	passive range of motion
PT	physical therapy; physical therapist
pt	patient
PTA	prior to admission; physical therapist assistant
PWB	partial weight bearing
Px	physical examination
q	every
q.d. *or* qd *or* QD	every day (quaque die)
q.h. *or* qh	every hour (quaque hora)
q.o.d. *or* qod *or* QOD	every other day
qt	quart
quads	quadriceps
R	reflexes
(R) *or* R	right
R/A	room air
R base	base of right lung
re	regarding, about, concerning
RGN	registered general nurse
RIP	rest in peace
RLL	right lower limb; right lower lobe
RMHN	registered nurse for the mentally handicapped
RMN	registered mental nurse
RN	registered nurse
ROM	range of motion
RPT	registered physical therapist
RPTA	registered physical therapist assistant
RR	respiratory rate
RROM	resistive range of motion
RRT	registered respiratory therapist
RSCN	registered sick children's nurse
RSF	right side flexion
RSI	repetitive strain injury
RTA	road traffic accident
RTI	respiratory tract infection
RUL	right upper limb; right upper lobe
Rx	prescription; treatment
S	single
SaO_2	arterial oxygen saturation
SAT	scholastic aptitude test
Sats	saturation
SCI	spinal cord injury
SDH	subdural haematoma
SDM	substitute decision-maker
SE	side effects
SED	seriously emotionally disturbed
sEMG	surface electromyographic
SHA	Strategic Health Authority
shd.	shoulder
SHI	social health insurance
SHx	social history
SI	sensory integration
SLI	specific language impairment
SLP	speech-language pathology; speech-language pathologist
SLR	straight leg raise
SLT	speech and language therapy; speech and language therapist
SLTA	speech and language therapist assistant
SNF	skilled nursing facility
SOAP	subjective, objective, assessment, plan
SOB	shortness of breath
SP	speech
SpO_2	arterial oxygen saturation
SSLI	severe speech and language impaired
STG	short-term goal
sup *or* SUP	supination
SW	social worker
Sx	symptom
T	tone
TATT	tired all the time
TBI	traumatic brain injury
TCI	to come in
temp	temperature
TENS *or* TNS	transcutaneous electrical nerve stimulation
trach	tracheostomy
Tx *or* tx	treatment; therapy; thoracic
UL	upper limb; upper lobe
ULL	upper left limb; upper left lobe
UOS	upper oesophageal sphincter

URL	upper right limb; upper right lobe
UTA	unable to attend
VAS	visual analogue scale
VFE	videofluoroscopic examination
VFSS	videofluoroscopic swallow study
VOCA	voice output communication aid
vol.	volume
VRE	vancomycin-resistant enteroccoci
W	widowed
w/	with
WB	weight bearing
w/c *or* wc	wheelchair
WCPT	Word Confederation for Physical Therapy
WD	well-developed
WFL	within functional limits
WFOT	World Federation of Occupational Therapists
wks	weeks
WNL	within normal limits
w/o	without
WOB	work of breathing
wt	weight
x	times (e.g., x 1 = one person)
yd.	yard
y/n	yes/no
y/o *or* y.o.	years old
yr	year
Z/F	Zimmer frame

8.2 General Grades of Specialization of OTs, PTs and SLTs in the UK

Therapy Assistants

Therapy assistants or attendants support the work of therapists. In the UK they carry out documented treatment plans, but cannot assess patients or make clinical decisions about treatments.

Junior, Basic or Staff Grade

Newly qualified AHPs usually on rotations between different clinical settings (i.e., Orthopaedics, Paediatrics, Medical…). They will have to work as Junior therapists for 1 ½ to 2 years before they are entitled to apply for a Senior II position. Furthermore, they are under supervision of a Senior therapist who looks after them and whom they will report to if questions arise or problems occur.

Senior II Grade

Rotational and sometimes one or two specialities. Post largely independent and only occasional report to a Senior I. Senior II therapists generally work for a further two years before they are eligible to apply for a Senior I position.

Senior I Grade

Senior I therapists are specialised practitioners who work in one specific clinical area only.

Superintendent IV, III, II, I Grade

Senior I Grades have given up some part of their clinical work to take on managerial duties to manage a therapy department.

Clinical Specialist

Clinical specialists are therapists who have specialist knowledge (e.g., a master's degree or a postgraduate higher diploma).

Extended Scope Practitioner

Extended scope practitioners are therapists who have taken on some roles which traditionally fall outside of the classic scope of therapy practice, such as patient assessments usually carried out by medical registrars or administering of corticosteroid injections.

Consultant Therapists

This is the highest clinical post for therapists. It combines clinical work and developing protocols and services.

University Lecturers and Researchers

8.3 Therapy Materials and Equipment

Materials and equipment typically used in the major areas of physiotherapy practice

In the cubicle:	In der Behandlungskabine:
coat hanger	Garderobenhaken, Kleiderbügel
plinth	(Behandlungs)liege
plinth cover	Behandlungstuch
tape measure	Maßband, Bandmaß
goniometer	Goniometer, Winkelmesser
assessment leaflet	Befundungsbogen
sink	Waschbecken
treatment gloves	Behandlungshandschuhe
hand disinfectant gel	Handdesinfektionsgel
antiseptic wipes	Desinfiziertücher
Tubigrip	elastischer Verband zur Kompression
info leaflet	Info-Flyer
exercise sheet	Übungszettel
taping tape	Tapingband
scales	Waage

In the gym:	Im Trainingsraum:
ergometer	Ergometer
treadmill	Laufband
stepper	Stepper
pulley slings	Schulterübungsbänder
weights	Gewichte
dumb-bells	(Kurz)hanteln
rubber exercise bands	Theraband
therapy putty	Therapieknete
parallel bars	Barren
traction table	Traktionstisch
tilt table	Kipptisch
standing frame	Freistehbarren, Stehständer
wobble board	Schaukel-, Wackelbrett
gym ball	Pezziball
therapy mat	Therapie-, Behandlungsmatte
exercise stairs	Übungstreppe
active/passive trainer	Gerät zum Trainieren der Arme und Beine
trampoline	Trampolin
CPM (continuous passive movement) machine	CPM-, Bewegungsschiene
hot pack machine	Gerät zur Erwärmung von Wärmeträgern (einem Fangoofen ähnlich)
hot wax	Heißwachs
TENS machine	TENS-Gerät

– ultrasound	Ultraschall
– laser	Laser
– hydro pool	Bewegungsbad, Therapiebecken
Physiotherapy stores:	**Materiallager:**
– elbow crutches	Unterarmgehstützen
– Zimmer frame	Gehgestell ohne Räder
– rollator frame	Gehgestell ohne Räder
– walking stick	Gehstock
– tripod	Dreipunktstock, Dreipunkt-Gehhilfe
– wheelchair	Rollstuhl
– insole	Einleg(e)sohle, Schuheinlage
– heel wedge	Keil zur Fersenerhöhung
– poly sling	Arm-, Schulterschlinge
– Tailor brace	Korsett für Wirbelsäulenfraktur
– wrist support brace	Handgelenksschiene
– lumbar support brace	Lendenwirbelsäulenstütze
– splint	Schiene
– Donjoy brace	Donjoy-Schiene, Donjoy-Orthese
Chest physiotherapy:	**Physiotherapie bei Atemwegserkrankungen:**
– stethoscope	Stethoskop
– incentive spirometer	Incentive-Spirometer
– flutter	Flutter (Atemgerät bei COPD)
– Tri-Ball	Tri-Ball, Triflow (Atemgerät für die Expiration)
– peak flow	Peak Flow
– nebuliser	Inhalationsgerät
– nasal prongs	Nasenklemme
– face mask	Mundschutz, Gesichtsmaske
– CPAP	CPAP-Beatmungsgerät
– suctioning catheter	Absaugkatheter, Absaugschlauch
– Yankaur	Absauggerät für den Mund- und Rachenraum
– gown	Ganzkörperumhang, Schutzanzug, Kittel
– apron	Plastikschutz, -schürze
– Sats monitor	Pulsoximeter
– sputum trap	Behälter für eine Sputumprobe
– monkey pole	Bettgalgen, Patientenaufrichter
– hoist	Patientenlifter
– standing hoist	Stehlifter

Materials and instruments typically used in the major areas of occupational therapy practice

Adaptive equipment for activities of daily living (ADL):	Adaptive Geräte für Alltagsaktivitäten (ATL):
Positioning devices:	**Vorrichtungen für die Körperstellung:**
– stryker frame (used to turn prone spinal cord injured patients)	Drehtisch, Spezialbett zum atraumatischen Umlagern von PatientInnen mit instabilen Wirbelsäulenfrakturen
– adaptive chair	angepasster Stuhl
– standing table (used to support and hold a standing position)	Stehtisch, Kipptisch (für neurologische Patienten)
– adjustable-height table	höhenverstellbarer Tisch
Assistive devices for dressing:	**Hilfsmittel beim Anziehen:**
– velcro straps	Klettverschlüsse
– sock aid	Anziehhilfe für Socken und Strümpfe; Strumpfanzieher
– adjustable-length pinchers	verlängerbare Greifzange
– adaptive clothing	Spezialkleidung, die das Anziehen erleichtert
Assistive devices for cooking and eating:	**Hilfsmittel beim Kochen und Essen:**
– anti-slip material	Antirutsch-Material
– adapted bowls, spoons, forks, knives	adaptierte Schüsseln, Löffel, Gabeln, Messer
– cutting board	Schneidebrett
– potato peeling board	Kartoffelschälbrett
– tin opener	Dosenöffner
Assistive devices for bathing:	**Hilfsmittel im Bad:**
– grab bars	Haltestangen
– bathtub bench	Badewannenbrett
– railing for shower and toilet areas	Geländer (Haltegriffe) für Dusch- und Toilettenbereich
Ambulatory aids:	**Gehhilfen:**
– wheelchair (manual or power)	Rollstuhl (ohne Eigenantrieb oder elektrisch)
– hoist	Patientenlifter
– walker	Walker, Gehwagen, Rollator, Gehgestell
– braces	Schienen; orthopädische Schalen
– crutches	Gehstützen

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– canes	Gehhilfe, Gehstock, Handstock
– prostheses	Prothesen
Assessments/evaluations (e.g., for measurements of function):	**Assessments (z. B. für die Funktionsmessung):**
– ADL inventory	Bestandsaufnahme bei Alltagsaktivitäten
– cognitive performance tests	Test zur kognitiven Fähigkeit
– perceptual motor evaluations	Evaluation der Wahrnehmungs- und motorischen Fähigkeiten
– motor proficiency tests	Tests der motorischen Leistungsfähigkeit
– functional performance tests	motorische Fertigkeitstests
– work evaluations	Arbeitsevaluationen
– dynamometer	Kraftmesser
– pinch gauge	Pinch-Gauge (Kraftmessinstrument, das Handgreif- und Fingeroppositionskraft misst)
Splinting materials:	**Schienenmaterial:**
– thermoplastics to form splints for various functions	Thermoplast, um Schienen für verschiedene Funktionen herzustellen
– strapping materials usually with velcro to fasten the splints onto appendages	Befestigungsmaterialen, gewöhnlich mit Klettverschluss, um Schienen an Gliedmaßen zu fixieren
Developmental learning materials:	**Entwicklungs- und Lernmaterialien:**
– peg boards	Steckspiele
– blocks	Bauklötze
– puzzles	Puzzle
– toy adaptations	angepasstes Spielzeug
– learning games	Lernspiele
Perceptual motor/sensory integration equipment:	**Wahrnehmungs- und Bewerungsausstattung/Ausstattung für sensorische Integration:**
– therapy ball	Therapieball, Pezziball
– ropes	Seile
– swings	Schaukeln
– slides	Rutschen
– bean baths	Bohnenbäder
– weighted vests	Gewichtjacke, Gewichtweste
– sandbags	Sandsäcke
– scooter boards	Rollbretter

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Assistive technology:	**Hilfstechnologie:**
– communication aids	Kommunikationshilfen
– alternative keyboards	speziell angefertigte Tastatur
– adaptive switches	angepasste Schalter
– word processors	Textverarbeitungsprogramme
– screen reader	Bildschirmleseprogramm
– adaptive driving equipment	angepasste Fahrzeugausstattung
Arts and crafts:	**Kunsthandwerk:**
– paper and paint	Papier und Farbe
– canvases	Leinwände
– brushes	Pinsel
– clay	Ton
– looms and frames	Webstühle und Spannbretter
– cloth	Stoff
– wool	Wolle
– basket weaving material (wicker)	Material zum Korbflechten (Peddigrohr)
– carving instruments	Schnitzwerkzeug
– scissors	Schere

Materials and tools often used in paediatric occupational therapy

Sensory processing materials:	**Materialien für die sensorische Verarbeitung**
for *vestibular stimuli:*	für *vestibuläre Reize*:
– swings	Schaukeln
– hammocks	Hängematten
– scooter boards, etc.	Rollbretter usw.
– for tactile stimuli:	für taktile Reize:
– cherry pits	Kirschkerne
– dried peas or beans	getrocknete Erbsen oder Bohnen
– brushes	Bürsten
– porcupine balls	Igelbälle
– massage tools, etc.	Massagegeräte usw.
for *proprioceptive stimuli:*	für *propriozeptive Reize:*
– mattresses	Matratzen
– weights	Gewichte
– ropes, etc.	Seile usw.
Materials for fine motor and hand skills:	**Materialien für feinmotorische Fähigkeiten und Handgeschicklichkeit**
– manipulative toys	Spielzeug mit aufforderndem Charakter
– blocks	Bauklötze
– balls	Bälle
– shapes, etc.	Formen usw.

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Materials for gross motor skills:	Materialien für grobmotorische Fähigkeiten:
– wall bars or climbing bars	Sprossenwand
– parachutes	Fallschirme
– tossing games	Wurfspiele
– balancing tools	Balance-Geräte
– trampoline, etc.	Trampolin usw.
– standardized training programmes	standardisierte Übungsprogramme
– memory improvement games	Spiele zur Gedächtnisstärkung
– worksheets	Arbeitsblätter
– behavioural training	Verhaltenstraining
– common children's parlour games	allgemein bekannte Gesellschaftsspiele für Kinder
– board games	Brettspiele
– puzzles	Puzzles
– crafting materials	Bastelmaterial
– clay	Ton
– wood	Holz
– crayons	Buntstifte, Farbstifte
– paints	Farben
– paper	Papier
– thread, etc.	Faden usw.
– various animating toys for indoors and outdoors	diverses anregendes Spielzeug für drinnen und draußen
– puppets	Handpuppen, Marionetten
– stuffed animals	Stofftiere
– dress-up clothes	Kleidungsstücke zum Verkleiden
– model cars	Modellautos
– bikes and tricycles, etc.	Fahrräder und Dreiräder usw.

Materials and equipment typically used in the major areas of speech and language therapy practice

Oral motor exam (oral peripheral exam):

– tongue depressor	Spatel, Holzspatel
– pocket flashlight or flashlight	Minitaschenlampe, Leuchtstift oder Taschenlampe
– gloves	Einmalhandschuhe

Motor Speech Exam and/or Speech (i.e., Articulation/Phonology, Dysarthria) Treatment:

– stopwatch	Stoppuhr
– mirror	Spiegel
– formal battery (e.g., Goldman Fristoe Test of Articulation or AIDS – Assessment of Intelligibility of Dysarthric Speech)	standardisierte Testbatterie, standardisiertes Testverfahren
– visipitch (for objective voice assessment)	Stimmfeldmessgerät

Swallowing:

– gauze (assessment and therapy)	Gaze (Befunderhebung und Therapie)
– swallowing "kit" – teaspoon/glass/water/ straw/food (applesauce, fruit cocktail, bisquit)	Material zur Schlucktherapie – Teelöffel/Glas/Wasser/Strohhalm/ Nahrung (Apfelmus, Fruchtcocktail, Keks)
– modified drinking glasses (e.g., nosy cup)	Trinkbecher mit ausgeschnittener Nasenkerbe oder speziellem Trinkaufsatz
– laryngeal mirrors	Kehlkopfspiegel
– ice chips	Eis-Chips
– thickening agents (e.g., Resource Thicken Up ©, Novartis ©)	Andickungsmittel für Getränke, Nahrungsmittelverdicker
– sEMG biofeedback	Oberflächen EMG als Biofeedback
– stethoscope (for cervical auscultation)	Stethoskop (zum Abhören von Brustgeräuschen)
– videoendoscopy or fiberoptic endoscopy	Videoendoskopie, FEES, Laryngoskopie
– TV & VCR (for VFS playback) or DVD	TV- und Videogerät (für das Abspielen von Videofluoroskopie) oder DVD

Communication (Language, Cognitive-Communication):

– formal language batteries [e.g., Rosetti Language Scales, Boston Naming Test (BNT), Scales of Traumatic Brain Injury (SCATBI)]	standardisierte Sprachtests
– informal assessment tools (e.g., checklists, inventories, algorithms)	informelle Prüfverfahren

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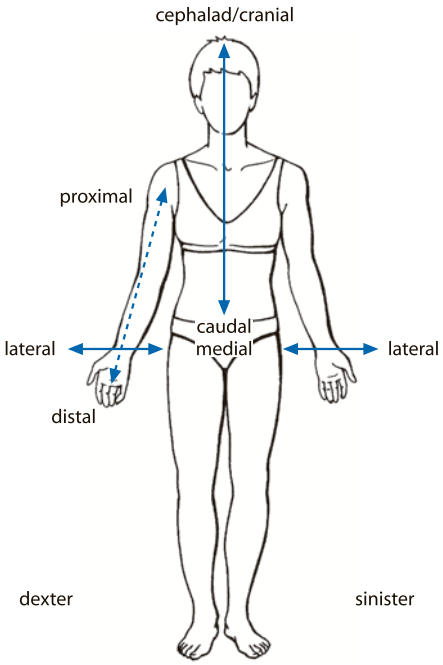
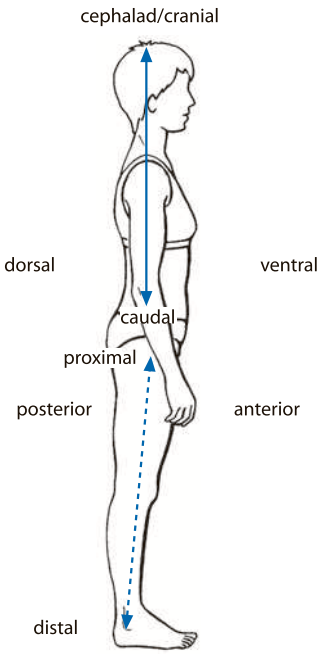
– language & cognitive workbooks	Sprach- und Kognitionsarbeitshefte
– toys & games (e.g., Mr Potato Head)	Spielzeug und Spiele
– articulation cards	Artikulationskarten, Laut(übungs)karten, Laut-Mundbilder
– children's books	Kinderbücher
– paper & pen	Papier und Stift
– augmentative and alternative communication (AAC) devices, including:	Hilfsmittel zur unterstützten Kommunikation inklusive:
– picture communication	– bildgestützte Kommunikation
– computers with voice output	– Computer mit Sprachausgabe
– electrolarynx	– Elektrolarynx, elektronische Sprechhilfe zur Tonerzeugung nach Laryngektomie
– stickers (i.e., reinforcement in therapy with children)	Aufkleber (zur Motivationsverstärkung in der Kindertherapie)
– coma management (sensory) stimulation material	Material zur taktilen oder sensorischen Stimulation (auch bei Wachkomapatienten)
– visual: e.g., photos, mirror, personal objects	– visuell: z. B. Fotos, Spiegel, persönliche Gegenstände
– auditory: e.g., voice (name), music	– auditiv: z. B. Stimme (Name), Musik
– tactile: e.g., cotton swab, sandpaper	– taktil: z. B. Wattetupfer, Wattestäbchen, Sandpapier
– olfactory: e.g., peppermint, Vicks ©, Tiger Balm ©, vanilla	– olfaktorisch: z. B. Pfefferminz, Vicks, Tigerbalsam, Vanille
– gustatory: e.g., ice, tea	– gustatorisch: z. B. Eis, Tee
– family photos & autobiographical photos	Familienfotos und Fotos von besonderen Erlebnissen
– memory books & other memory aids	Gedächtnistagebücher, Erinnerungsbücher und andere Gedächtnishilfen
– calendars (for orientation)	Kalender (zur Orientierung)
– objects or picture cards (of objects, actions, people etc.)	Gegenstände oder Bildkarten (mit Gegenständen, Tätigkeiten, Personen etc.)
– portable audiometer (for hearing screening)	tragbares/transportables Audiometriegerät/Audiometer (für das audiologische Screening)

8.4 Directions and Planes of Reference



frontal view



lateral view

horizontal	parallel to the floor	**medial**	towards the middle of the body
horizontal or transverse plane	a horizontal plane passing through the standing body parallel to the ground	**lateral**	towards the left or right side of the body
vertical	upright (opposed to horizontal)	**ventral**	towards the front side of the body
mid-sagittal or median plane	exactly down the midline, splits the body into left and right halves	**dorsal**	towards the back side of the body
sagittal	a vertical plane through the standing body from front to back parallel to the midline	**rostral**	towards the nose
coronal or frontal plane	divides the body into dorsal and ventral portions	**superficial**	near the surface
anterior	in front (of)	**deep**	away from the surface, further into the body
posterior	behind (to the back)	**internal**	within, inside
distal	towards the free end of the extremity	**external**	out of, outside
proximal	towards the root of the extremity	**superior**	further above
dexter	located on or relating to the right side	**inferior**	further below
sinister	located on or relating to the left side	**caudal**	below another structure; situated in or toward the tail or hind part

palmar	towards the palm of the hand	**cephalad or cranial**	towards the head
plantar	towards the sole of the foot	**caudad**	towards the feet
central	relating to a centrum	**prone**	lying face down
peripheral	of the surface or outer part of the body or an organ	**supine**	lying face up

8.5 Human Locomotion

extension	straightening an extremity along an axis
flexion	bending an extremity along an axis
abduction	moving to the side, away from the midline of the body
adduction	moving towards the midline of the body
internal rotation	moving from neutral position to front and centre
external rotation	counter movement to front and side
circumduction	circular movement of a body part (a combination of flexion, extension, adduction, and abduction)
elevation	moving in a superior direction
depression	moving in an inferior direction
pronation	rotating the forearm to the inner side so that the palm is moved from an anterior-facing position to a posterior-facing position
supination	rotating the forearm to the outer side so that the palm faces anteriorly
medial rotation	rotating the forearm when the arm is half flexed so that the palm is moved from an anterior-facing position to a posterior-facing position
eversion	moving the sole of the foot away from the median plane
inversion	moving the sole of the foot towards the median plane
dorsiflection	flexing the entire foot superiorly, or upwards
plantar flexion	flexing of the entire foot inferiorly, or downwards

8.6 Useful Phrases for Patient Communication

Making an Appointment

- My working hours are between 9 a.m. and 5 p.m. Mondays, Wednesdays and Fridays.
- Would you be available for an initial consultation on Monday, August 29 at 1 p.m.?
- Sorry, I am not available at 2:30 p.m. but I could see you between 3 and 4:00 pm.
- Would you mind dropping by my office just after lunch?
- I would like to make an appointment with both you and your husband to discuss the results of your voice assessment. Will you both be able to make it in next Thursday? I have morning appointments still available then. What time would work well for you?
- Will your son be coming as well?
- Your therapy time is between 9 and 10 every morning.

Greetings/Introducing Yourself

- Good morning. Please come in and sit down.
- Good morning, Mrs Robertson. Do take a seat.
- Hello, my name is Louise. I am the occupational therapist at this unit.
- Hello. I am the speech and language therapist. My name is Hector.
- My name is Jamie and I will be your physiotherapist.
- Dr Rivers referred you to me to help you return to your job.
- Hi Kelly! Good to see you again! How are things?

Taking a History / Doing an Examination

Learning about the Problem

- **What** is the pain like?
- Can you tell me about the problem that has brought you here today?
- How can I help you today?
- Please describe the problem.
- **Where** is the pain exactly?
- Where is the sore spot?
- Can you show me where it hurts?
- **When** did you first notice this?
- When did the problem begin?
- When did the trouble first start?
- **How long** have you had this pain?
- How long has this been going on?
- How long has the pain been bothering you?
- How did it begin? Gradually? Suddenly?
- Has the problem changed since it was first noticed? Gotten better? Gotten worse?
- How do you react or respond to the problem? Does it bother you? What do you do?

History of Present Illness

- Do you get headaches?
- Do you ever have dizzy spells?
- Have you ever fainted?
- Have you ever blacked out?
- Have you ever had a head injury?
- Do you feel agitated?
- Do you ever get a tingling feeling in your arms, hands or legs?
- Does it hurt if you bend your knee?
- Do you have any difficulty moving your arms or legs?
- Have you had any falls?
- Do you feel any weakness in your limbs?
- Does the knee feel tender there?
- Do your muscles feel stiff in the morning?
- Have you noticed any twitching of your muscles?
- Have you ever lost your voice? If so, how often?
- Have you ever been seen by an ear, nose and throat (ENT) physician for any problems with your voice, throat or swallowing?
- Do you cough or choke when eating and drinking?
- When did the problems with swallowing begin?
- Have you ever had pneumonia?
- Is your mouth and/or throat irregularly dry?
- Do others have a hard time understanding you?
- Do you have problems with your memory?
- Do you have difficulties remembering the names of people or places?
- What goals would you want to achieve?
- Tell me about the activities you usually do on a typical day.
- Do you need any help with bathing, dressing, or cooking meals?
- When did you notice a change in your ability to carry out your daily routines?
- Do you have any difficulty walking up stairs? Have you got stairs or steps in your home?
- Can you work with your hands well or do you have any trouble performing routine activities?
- How do you get along with other people?
- Are you self-conscious or do you get embarrassed easily?
- Are you generally in a good mood or do you have ups and downs that change from day to day?
- Would you describe yourself as a happy and contented person?
- Do you often lose your temper?
- Do you always need to follow a set routine?
- Do you react overly emotional at times?
- Do you usually have lots of energy?
- Do you find it difficult sometimes to cope with the demands of everyday life?

Explaining, Obtaining Consent and Providing Reassurance

- The results of your ear, nose and throat (ENT) assessment confirm that you have vocal nodules.
- You appear to have a severe swallowing problem.

- It seems that Louisa's expressive language skills are delayed.
- His difficulty with understanding and speaking is because of a language problem called "aphasia".
- First I'll take a look at your face muscles and the inside of your mouth, then I'll ask a few questions about your voice.
- You will feel a tingling going through, it should be strong but not uncomfortable...
- This is a hot pack. It should be warm but not hot. If it becomes too hot, please tell me! It helps to relax the muscles.
- This home exercise programme will help to strengthen your muscles so you can complete your tasks more easily.
- You should be able to relax. If it gets painful or uncomfortable, please tell me.
- I would like to assess your swallowing.
- I would like to check the range of motion in your shoulder.
- I would like to examine your speaking skills. This will include asking a series of questions. Some questions will require you to listen, others to talk, write or draw.
- Do you mind if I touch your arm while I'm doing my evaluation?
- You are doing a great job answering these questions. Keep up the good work!
- Your answers to my questions are fine. You are doing exactly what is expected.

Establishing Therapy Goals

- Which goal would be the priority for you, Mario: working on writing or drawing messages?
- The assessment we completed in the last week showed that you have several areas of strength including listening and reading comprehension and writing. What is more difficult for you is your ability to say individual sounds and to form grammatically correct sentences when speaking. I would suggest that we work on those two areas, that is, articulation and grammar to help you improve your talking ability.
- What would you like to improve with therapy?
- Do you have any specific goals in mind for your husband, Mrs Thatcher?
- Would you be interested in using a computer or a book with pictures to help you speak/communicate better?

Giving Instructions during Assessment or Treatment

- Stick out your tongue, please.
- Clear your throat. Cough.
- Take in a deep breath and say "ah" and hold it for as long as you can. I will be timing you. You can start when you feel ready.
- Say "puh"-"tuh"-"kuh" as fast and as clearly as you can.
- Just raise your leg for a second… Good.
- Please hold out your arms for a second…
- Take a few steps forward.
- Bend down, please.
- Move only as far as you can.
- Put your hands on your back.
- Point to the ceiling and then to the floor.
- Try to touch the floor with your finger tips.
- Could you give me your arm?
- Right. Could you just take off your blouse for a second?
- Can you bend over and touch your toes?
- Tighten up your tummy while doing this exercise.
- Do your exercise at least twice a day.
- Please do your warm-up first.

Feedback to Patient during Treatment

- Well done, Jan!
- Your speech has certainly improved in comparison to last week.
- That was perfect. Do that again, exactly as you just did.
- Again, please!
- Not quite, try again.
- Mr Seebacher, you need to stay awake.
- Let's try that five more times!
- Way to go!! That was awesome! (Only said to children)

Saying Goodbye

- I'll be coming by again tomorrow.
- See you later.
- See you then!
- Bye!

How Your Clients May Respond to Your Questions

- I'm in pain.
- My … hurts.
- My … aches.
- I've got a bad …
- I've got a pain in …

- I've twisted / pulled / wrenched / strained a muscle in.
- I have backache.
- I've pulled / wrenched a muscle in my back.
- I've done my back in.
- I've knackered my back.
- I think I've slipped a disc.
- I've pulled a muscle in my leg.
- I get a cramp in my legs / calves / thighs.
- I've torn a ligament.
- I've sprained a ligament.
- I've snapped a tendon in my thigh.
- I've bruised my leg.
- My foot keeps going to sleep.
- I get pins and needles in my feet.
- I've sprained / turned my ankle.
- I've twisted / strained my wrist.
- I feel a tingling sensation in my fingers.
- My fingers have gone numb.
- My fingers have started trembling a lot.
- My hands are shaking.
- I get out of breath easily.
- I find it difficult to breathe.
- I'm fighting for breath.
- I've got a splitting / severe headache.
- I feel drowsy.
- I feel dizzy.
- I can't cope.
- I can't go on.
- I get easily irritated.
- I'm in no mood to do anything.
- My memory's going.
- I have difficulty remembering things.
- I'm / I feel…
  … depressed / fed up / listless / tired / exhausted / moody / miserable / down in the dumps / bogged down / at the end of my tether / out of sorts / off the wall.

8.7 Useful Phrases for Presentations and Discussions

Greeting the Audience

- Hello everybody.
- Good morning / evening / afternoon, ladies and gentlemen.
- Welcome to…
- I am pleased to see such a good turn-out today.
- I would like to thank everybody for attending my presentation today.

Introducing and Outlining the Topic of the Talk

- My presentation / talk deals with...
- My presentation / this talk is concerned with...
- The topic of my talk is...
- I have chosen this topic because I am particularly interested in...
- My own research emphasis is in (the field of)...

Dividing the Main Part into Various Points

Enumerating the Elements:

- Firstly…, secondly…, thirdly....
- First…, then…, afterwards…, next…, after that…, before turning to...
- Finally…/lastly…/at last…
- On the one hand… and on the other hand…

Adding Another Point:

- Furthermore,…
- Just one further remark…
- In addition to this…
- It must also be said that…

Introducing an Example:

- For example,…
- Take for example…
- To illustrate this…

Considering Counter-Arguments:

- However, there are other issues to consider.
- However, this is just one side of the matter.
- However, we must not forget that…
- Let us now consider…
- On the other hand, …

Summarizing the Arguments

- Summarizing / In summary it can be stated / said that
- To recapitulate, ...
- We have seen/established that…

Drawing Conclusions:

- Concluding / In conclusion…
- All of these facts lead me to the conclusion that…
- From all this I must conclude that…
- What conclusions can be drawn from this analysis?
- I've come to the conclusion that…

Thanking and Praising

- This talk was very informative / refreshing / challenging / exciting / original.
- This talk has given me plenty to think about/ lots of new insights.
- Your remarks about… were really to the point.
- Interestingly, you mentioned that...

Clarifying Unclear Points

- If I understood you correctly you were saying that...
- I'm afraid I didn't quite get what you were saying about...
- Could you perhaps clarify what you mean by...
- I'm afraid I don't follow why…
- But what's the point of…?
- I don't quite see why…
- Could you tell us why…?

Expressing One's Opinion

- I am convinced that…
- I personally believe that…
- In my opinion…
- It seems to me that…
- My own point of view is that…
- From my point of view …
- I firmly believe that…
- As I see it…
- The point is…
- As far as I'm concerned…
- It's quite clear to me that…

Agreeing

- I wholly agree with you.
- I absolutely agree.
- I am totally of your opinion.
- I have nothing to add.
- I subscribe to that opinion.
- I am all for it.
- I think so, too.
- I'm with you all the way.
- Yes, I think you're absolutely right.

Agreeing Partly

- I agree up to a point, but…
- I see what you mean, but…
- That's true in a way, but…
- Most of what you say is true, but…
- I agree on the whole, but I just can't accept that point you made about…

Disagreeing

- I disagree.
- No, I'm afraid I don't agree, because…
- I can't accept that, I'm afraid, because…
- The main reason I disagree is…
- I don't really agree.
- I think you're wrong.
- I'm afraid I can't accept that.
- I don't really think that's right.
- I have my doubts.
- I beg to differ / to take another view.
- I must take issue with you.
- Our opinions are diametrically opposed.
- You have failed to convince me.
- That's an interesting point, but you don't seem to realize that…
- This is open to interpretation.

Interrupting

- Excuse me…
- Can / May I just come in here?
- Can / May I interrupt for a moment?
- Just a minute.
- One moment, please.

8.8 Key – Lösungsschlüssel

Unit 1.2 – Exercise Opposites

1. ill; 2. minor; 3. alive; 4. chronic; 5. mild; 6. malign; 7. acquired; 8. susceptible; 9. tense (relating to persons) or tensed (relating to muscles); 10. robust

Unit 1.3 – Some Commonly Encountered Medical Conditions

1. apraxia; 2. chronic obstructive pulmonary disease (COPD); 3. cerebral palsy; 4. dysphagia; 5. juvenile arthritis; 6. back pain; 7. stress incontinence; 8. stuttering 9. asthma 10. cerebrovascular accident (CVA) 11. aphasia 12. Alzheimer's 13. repetitive strain injury (RSI) 14. cystic fibrosis 15. dysarthria 16. lymphoedema 17. dementia 18. sciatica 19. catatonia 20. obsessive-compulsive disorder 21. paraplegia (PARA) 22. fatigue 23. psychosis 24. muscular dystrophy (MD) 25. acquired deafness

Unit 1.4 – Exercise Medical Specialities

1. general practitioner (GP) 2. psychiatrist 3. paediatrician 4. orthopaedist 5. surgeon 6. emergency physician 7. anaesthesiologist

8. geriatrician 9. obstetrician and gynaecologist (ob/gyn) 10. ophthalmologist 11. dentist 12. otorhinolaryngolgist (or ENT specialist)

Unit 1.6 – The Health Care System of the UK: The National Health Service (NHS)

1. National Health Service 2. Primary Care Trusts 3. Department of Health 4. Strategic Health Authority 5. doctors' surgery 6. emergency 7. elective 8. elective care patients 9. outpatient 10. psychological therapy 11. mental health

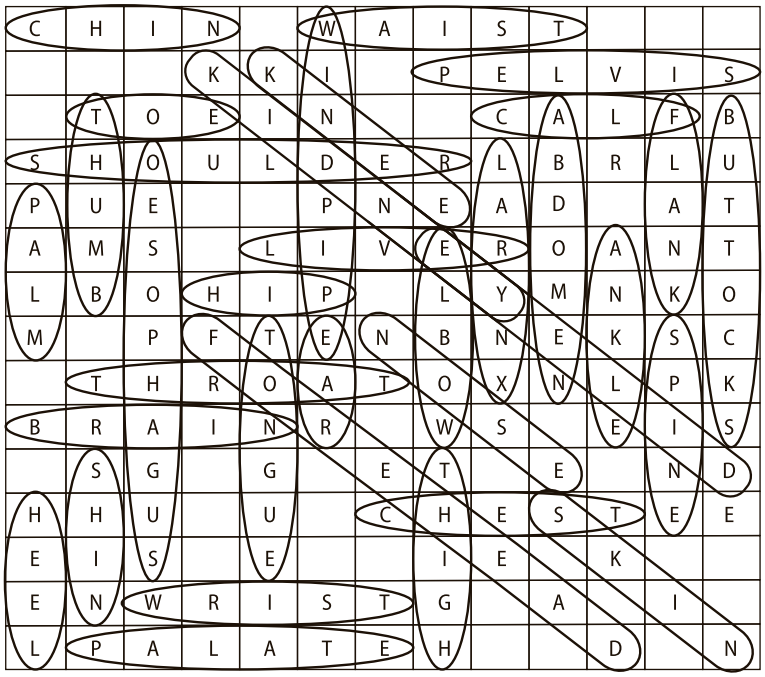
Unit 1.7 – Health Care in the USA

1. private 2. employers 3. employees 4. premiums 5. deductibles 6. co-payments 7. managed care 8. HMOs 9. PPOs 10. contracted providers 11. per capita 12. primary care provider 13. public 14. uninsured

Unit 1.8 – Health Services in the USA

1. residential care facility 2. Meals on Wheels 3. psychiatric rehabilitation services 4. early intervention 5. age-integrated housing 6. outreach services 7. skilled nursing facility (SNF) 8. adult day care 9. hospice programme 10. sheltered housing 11. home health care

Unit 2.1 – Basic Anatomical Terms (p. 26)



1. = i 8. = t 15. = s 22. = gg 29. = ee
2. = f 9. = n 16. = h 23. = a 30. = g
3. = dd 10. = p 17. = e 24. = v 31. = l
4. = y 11. = d 18. = j 25. = aa 32. = cc
5. = m 12. = k 19. = hh 26. = w 33. = ff
6. = q 13. = z 20. = bb 27. = c 34. = o
7. = u 14. = b 21. = ii 28. = r 35. = x

Unit 2.2 – The Anatomy of the Human Body

1. = trunk 2. = abdomen 3. = perineum 4. = vertebral column 5. = head 6. = upper limb 7. = lower limb 8. = upright 9. = together 10. straight forward 11. = to the side of the body 12. forwards 13. = anatomical position 14. = down 15. = supine 16. = prone 17. through 18. = median 19. = longitudinal 20. = left 21. = right 22. = parallel 23. = midline 24. = lateral 25. = trachea 26. = vertical 27. =

anterior 28. = posterior 29. = front 30. = back 31. = chest 32. = nose 33. = perpendicular 34. = horizontal 35. = upper 36. = lower 37. = mouth 38. = forehead 39. = near 40. = breastbone 41. = nearer 42. = further 43. = knee 44. = foot

Unit 2.3 – The Parts of the Body

1. = vertex, top of the head 2. = back of the head 3. = forehead 4. = temple 5. = eye 6. = ear 7. = nose 8. = cheek 9. = mouth 10. = chin 11. = jaw 12. = neck 13. = throat 14. = nape *or* back of the neck 15. = shoulder / shoulder joint 16. = shoulder blade *or* scapula 17. = armpit *or* axilla 18. = chest *or* thorax 19. = breast 20. = rib 21. = back 22. = vertebral column *or* spinal column *or* spine 23. = trunk 24. = upper arm 25. = crook of the arm *or* cubital fossa 26. = elbow 27. = forearm 28. = wrist 29. = hand 30. = dorsum of the hand *or* back of the hand 31. = palm of the hand 32. = finger 33. = thumb 34. = index *or* index finger *or* forefinger 35. = knuckle 36. = waist 37. = flank 38. = belly *or* abdomen 39. = hip / hip joint 40. = groin 41. = buttock 42. = thigh / thighbone, femur 43. = knee / kneecap *or* patella 44. = hollow of the knee *or* back of the knee *or* popliteal fossa 45. = lower leg 46. = calf / calf bone *or* fibula 47. = shin *or* shinbone *or* tibia 48. = ankle / ankle joint 49. = foot 50. = dorsum of the foot *or* back of the foot 51. = sole 52. = heel 53. = toe 54. = big toe

Unit 2.4 – Compound Words in Anatomy

1 = D; 2 = C; 3 = H; 4 = O; 5 = L; 6 = I; 7 = J; 8 = B; 9 = N; 10 = M; 11 = E; 12 = K; 13 = P; 14 = G; 15 = A; 16 = F; 17 = Q

Unit 2.5 – The Brain and Nervous System

1. peripheral nervous system 2. neuron 3. central nervous system 4. motor neuron 5. sensory neuron 6. axon 7. myelin sheath 8. neurotransmitter 9. brain 10. spinal cord 11. somatic nervous system 12. frontal lobe 13. occipital lobe 14. temporal lobe 15. parietal lobe 16. cerebellum 17. brain stem 18. pituitary gland 19. hypothalamus 20. thalamus 21. gyrus 22. sulcus 23. ventricular system 24. basal ganglia 25. cerebrum 26. hippocampus

Unit 2.6 – Human Locomotion

1. flexes (flexion) 2. everts (eversion) 3. externally rotates (external rotation) 4. extends (extension) 5. internally rotates *or* medially rotates (internal rotation *or* medial rotation) 6. pronated (pronation) 7. supinated (supination) 8. dorsiflexes (dorsiflexion) 9. elevates (elevation) 10. depresses (depression) 11. circumducts (circumduction) 12. abducts (abduction) 13. inverts (inversion) 14. plantar flexes (plantar flexion) 15. adducts (adduction)

Unit 2.7 – The Physiology of Voice

1. medulla oblongata 2. diaphragm 3. deflation 4. larynx 5. thyroid cartilage 6. tension 7. organs of articulation 8. blocking 9. oral and nasal cavities

Unit 2.8 – The Larynx and Thoracic Cavity

Innervation of the Larynx

1. = hyoid bone 2. = thyrohyoid membrane 3. = thyroid cartilage 4. = cricothyroid membrane *or* cricothyroid ligament 5. = cricoid cartilage 6. = thyroid gland 7. = inferior thyroid artery 8. = (right) vagus nerve 9. = recurrent laryngeal nerve 10. = superior vena cava 11. = aortic arch 12. = phrenic nerve 13. = superior laryngeal nerve 14. = internal branch of superior laryngeal nerve 15. = external branch of superior laryngeal nerve 16. = cricothyroid muscle 17. = oesophagus 18. = (left) vagus nerve 19. = common carotid or common carotid artery 20. = subclavian artery 21. = rib 22. = bronchi (main/primary bronchi) 23. = pulmonary artery 24. = heart 25. = diaphragm

Thoracic Cavity

1. = falx cerebri 2. = pituitary gland 3. = epiglottis 4. = windpipe *or* trachea 5. = apex of lung 6. = clavicle 7. = first rib 8. = nipple *or* mammary papilla 9. = phrenicocostal recess/sinus *or* costodiaphragmatic recess/sinus 10. = liver 11. = gallbladder 12. xiphoid process 13. sphenoidal sinus 14. = frontal sinus 15. = superior/middle/inferior nasal concha *or* superior middle/inferior turbinate bone 16. = eustachian tube 17. = tongue 18. = aorta 19. = cardiac notch 20. = dome of the diaphragm 21. = costomediastinal recess *or* costomediastinal sinus 22. = spleen 23. = stomach

Unit 2.10 – Human Anatomy in English Proverbs and Sayings

1. = B; 2. = A; 3. = C.; 4. = D.; 5. = D.; 6. = B.; 7. = D.; 8. = C.; 9. = B.

Unit 3.1 – Allied Health Professions

1. art therapy 2. audiology 3. medical technology 4. respiratory therapy 5. dietetics 6. paramedics 7. orthoptics 8. physiotherapy 9. occupational therapy 10. speech and language therapy 11. prosthetics and orthotics 12. music therapy

Unit 3.6 – Therapeutic Treatment Methods in Occupational Therapy and Speech and Language Therapy

1. = establishing a therapeutic relationship 2. = ADL-training 3. = arts and crafts 4. = fine motor training 5. = social competence training 6. = mobility training 7. = perceptual and cognitive training 8. = sensory integration therapy 9. = splinting techniques 10. = neuromuscular facilitation 11. = relaxation 12. = resonance management 13. = fluency training 14. = vocal hygiene 15. = supportive communication 16. = aphasia therapy 17. = cognitive-communication therapy 18. = articulation training 19. = respiration training (for speech) 20. = oral-motor exercises 21. = aural rehabilitation 22. = augmentative and alternative communication (AAC)

Unit 3.7 – Physiotherapy Fields of Activity and Clinical Practice

1. = neurology 2. = intensive care 3. = oncology and palliative care 4. = sports medicine 5. = respiratory care 6. = cardio rehabilitation 7. = orthopaedics 8. = vascular surgery and rehabilitation of amputees 9. = women's/men's health 10. = musculoskeletal 11. = rheumatology 12. = paediatrics 13. = traumatology

Unit 3.11 – The Multi-Professional Setting within a Hospital in the United Kingdom

A. = 1. B. = 4. C. = 8. D. = 10. E. = 6. F. = 2. G. = 11. H. = 7. I. = 3. J. = 9. K. = 5.

Unit 3.12 – Asking and Giving Directions

1. = at 2. = on 3. = in 4. = up to 5. = with 6. = with 7. = in 8. = of 9. = from 10. = in 11. = to 12. = for 13. = to 14. = at 15. = for 16. = down 17. = to 18. = at 19. = of 20. = up to 21. = to 22. = on 23. = through 24. = down 25. = to 26. = to 27. = to 28. = above 29. = at 30. = behind 31. = for 32. = on 33. = to 34. = on

Unit 3.14 – Instruments and Equipment in the Hospital

1. = commode 2. = blood pressure cuff 3. = tourniquet 4. = drip stand 5. = bed linen 6. = bandage 7. = bleeper 8. = leg bag 9. = stethoscope 10. = sling 11. = crash cart

Unit 4.1 – The Therapeutic Relationship and the Intervention Process

1. = referral 2. = collecting information, assessing client's needs 3. = analysing information 4. = deciding on treatment goals with the client 5. = planning the treatment 6. = providing treatment 7. = evaluating result 8. = reviewing the outcome, changing treatment if necessary 9. = terminating the treatment 10. = discharge

Unit 4.3 – Case History

1. = collecting 2. = habits 3. = taking 4. = admission 5. = chart 6. = interview 7. = gathering 8. = focus 9. = participation 10. = engagement 11. = occur 12. = contexts 13. = establishing 14. = profile 15. = intervention

Unit 4.4 – The Initial Assessment Interview – Basic Interview

1. = in 2. = on 3. = of 4. = after 5. = of 6. = on 7. = in 8. = on 9. = from 10. = to 11. = to 12. = during 13. = in 14. = down 15. = for 16. = during 17. = up 18. = during 19. = forwards 20. = of 21. = of 22. = on 23. = to 24. = in 25. = during 26. = for 27. = for 28. = of 29. = in 30. = in 31. = to 32. = for 33. = at 34. = of 35. = in 36. = by 37. = after 38. = through 39. = for 40. = with

Unit 4.6 – Documentation – SLT Case Notes

Demographic Information Ms. Dorothy Cummings DOB: Feb 21st, 1965 DOA to Hamilton General Hospital: Nov 6th, 2005	**Cognitive/Language** awake O x 1 (person, not time, not place) off-topic during conversation poor attention span didn't know that she was ill naming for common objects good, but didn't know what a stethoscope was followed 3 step commands
Medical Information ICB, Grade III, secondary to PICA aneurysm Sx: crani. & aneurysm clipping Nov 7th, 2008; re-opening of crani and re-clipping Nov 9th ICU Nov 7th to Nov 21st ETT ~ 2 weeks; self-extubated Nov 20th no trach NPO → NG chest – x-ray: Nov 20th RLL infiltrate	**Speech/Voice/Resonance** right facial weakness; facial droop speech: reduced artic.– bilabials in particular; slow rate – check further voice: breathy, probably dry, low volume resonance: ok swallowing: oral spillage; reduced bolustransport; oral residue; delayed swallow; laryngeal elevation okay; tho (i.e., though) coughing with large sips liquids
Social lives alone boyfriend no kids pt is a lawyer; has own, very successful law firm pt very social → "chatter-box" pt's hobbies: equestrian, rock climbing, reading, dinner parties pt typically "perfectionist" → would not want to be "disabled	**Relevant Medications** (relevant to swallowing) Domperidone Losec

Unit 4.7 – Giving Instructions

1. = take 2. = put 3. = taking 4. = have a look 5. = stand 6. = feel 7. = bend 8. = touch 9. = come 10. = keeping 11. = slide 12. = twist 13. = cross 14. = place 15. = lift 16. = turn 17. = turn 18. = stay 19. = remain 20. = bend 21. = place 22. = stand 23. = lift 24. = bend 25. = lift 26. = stand 27. = hold 28. = maintain 29. = lean 30. = lift 31. = lying 32. = lift 33. = bring 34. = lift 35. = keep 36. = give 37. = stay 38. = push 39. = hold 40. = hold 41. = change 42. = place 43. = pull 44. = roll 45. = lie 46. = hollow 47. = keep 48. = lift 49. = lying 50. = roll 51. = roll 52. = sit

Unit 4.8 – Clinical Reasoning Processes in Chest Physiotherapy

Q1: Fully compensated respiratory alkalosis as pH normal and pCO_2 and HCO_3 abnormal.

Q2: Position patient optimally to reduce WOB, e.g. forward lean sitting over pillows and apply face mask instead of NP on 4l. Contact patient's doctor on call to access further information regarding the patient and inform possibility of need to review prescribed O_2.

Q3: First possibility: The woman might suffer from a PE – young woman with no Hx of lung pathology, acute hypoxia (decreased oxygen) and pleuritic pain, Hx of DVT. Second option: She suffers from an RTI with possible pleural effusion – temperature raised, pleuritic pain, significant decreased a/e L base.

Q4: For example chest x-ray to determine RTI, Doppler or CT scan to determine PE, blood parameters to determine infection levels for example or INR (clotting time).

Q5: In positions of ease: relaxation techniques with optimal O_2 prescription, upper vertebral pressure or perioral pressure to encourage diaphragmatic breathing. If PE medical management is main priority.

If RTI diagnosed and PE ruled out: hot pack/TENS for pain relief while encouraging ACBTs. Flutter or PEP mask, but only if patient becomes less O_2 dependent and breathless while remaining to have difficulty with thoracic expansion.

Unit 4.9 – Interpretation of Test Results and Observations

Active Vocabulary

1 = perceptions 2 = observations 3 = emotion 4 = interpretation 5 = descriptions 6 = assumptions 7 = evaluation 8 = assessment

Exercise

Words to be reformulated (in order of appearance): "disoriented" "sceptical" "fearful" "tried to hide himself" "demonstrated tactile defensiveness" "is low" "has a poor body concept" "has an astute visual perception" "did not want to try out" "too unsure of himself" "very happy"

Unit 5.4 – Assistive Devices

a) = 3. b) = 6. = c) = 4. d) = 1. e) = 5. f) = 2.

Picture 1:

1. = e) 2. = l) 3. = d) 4. = a) 5. = h) 6. = g) 7. = i) 8. = c) 9. = m) 10. = b) 11. = j) 12. = k) 13. = n) 14. = f) 15. = o)

Picture 2:

1. = p) 2. = c) 3. = i) 4. = q) 5. = h) 6. = f) 7. = r) 8. = m) 9. = o) 10. = b) 11. = g) 12. = d) 13. = n) 14. = k) 15. = j) 16. = l) 17. = a) 18. = e)

Unit 5.5 – Areas Covered in Rehabilitation Programmes

a) = concentration; problem-solving abilities; memory b) = speech; AAC; writing c) = education about the medical condition; information on medical care; guidance with adaptive techniques d) = discharge planning; assistance with adaptation to lifestyle changes; support with financial issues e) = transfers; wheelchair use; walking f) = pain medication; alternative methods of managing pain g) = medication; nutrition; skin care h) = addressing attitude problems; dealing with emotional issues; addressing behavioural issues i) = ventilator care; breathing treatment; exercises to promote lung function j) = feeding; grooming; bathing; dressing; toileting k) = social interaction at home; social interaction in the community l) = work-related skills

Unit 5.8 – Neurological Patient Admission to Hospital – Example of a Hospital Medical Ward Chart Note

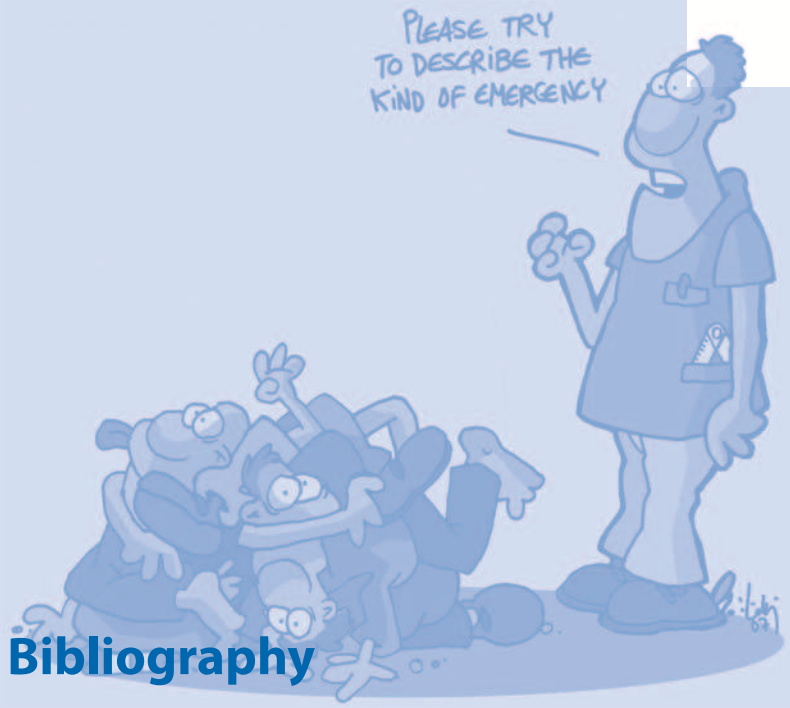
1. Ax (assessment)	2. Dx (diagnosis or discharge)	3. Ex (exercise)	4. Fx (fracture)
5. FHx (family history)	6. Hx (history)	7. PMHx (past medical history)	8.Px (physical examination)
9. Rx (prescription, treatment)	10. SHx (social history)	11. Sx (symptom)	12. Tx (treatment, therapy)

Unit 6.3 – Academic Writing: Research Report

= e) 2. = a) 3. = a) 4. = d) 5. = c) 6. = a) 7. = d) 8. = b) 9. = a) 10. = c) 11. = b) 12. = a) 13. = d) 14. = c) 15. = b) 16. = d) 17. = a) 18. = c) 19. = d) 20. = b) 21. = d) 22. = d)

Unit 7.2 – Registration Requirements in Canada: CASLPA & CASLPO

1 = professional association 2 = professional association 3 = employment 4 = body 5 = consumers 6 = exam 7 = professional initials 8 = designation 9 = fees 10 = accumulate 11 = reciprocity 12 = public interest 13 = in accordance with 14 = protects 15 = minimum 16 = complaints 17 = licence 18 = malpractice 19 = abbreviation 20 = college 21 = operable 22 = mentorship programme 23 = re-registration



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