Clinical Reasoning Case Studies as Teaching Tools

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Objective. Students are taught how to apply clinical reasoning methods through a variety of teaching methods, including the use of case studies. Various types of case studies have been described in the literature: paper cases, videotape cases, simulated client cases, and real client cases. This study examined the effectiveness of a new type of paper case study—the clinical reasoning case study—in teaching the clinical reasoning process to occupational therapy students.

Method. Four seniors in an undergraduate occupational therapy program completed intervention plans in response to both traditional medical model and clinical reasoning paper case studies. Qualitative methods were used to analyze intervention plans and videotaped discussion about this learning experience.

Results. Themes discovered in the data sources suggest that compared with traditional case studies, the clinical reasoning case studies increased the quality of participants' intervention plans, participants' confidence levels about their plans, and participants' understanding of the clinical reasoning process. Participants also reported preferring clinical reasoning case studies over traditional paper case studies.

Conclusion. The clinical reasoning case studies are effective teaching tools because they provide students with a holistic picture of the client and his or her occupational therapy treatment. In addition, these case studies model the clinical reasoning process by organizing client information according to the types of clinical reasoning that would be used to gather that information. Occupational therapy educators may find this type of paper case study useful in introducing students to the intervention planning process.

Clinical reasoning, the thought process clinicians use in practice, enables occupational therapy practitioners to individualize treatment, facilitate functional performance, and create positive outcomes for their clients (Fleming, 1991). Because clinical reasoning is the main process practitioners use to integrate client assessment information and develop intervention plans (Fleming, 1991; Parham, 1987; Rogers, 1983; Slater & Cohn, 1991), occupational therapy educators strive to teach clinical reasoning throughout their curricula. This study examined a new methodology for teaching clinical reasoning—the clinical reasoning case study.

Literature Review

Clinical Reasoning in Occupational Therapy

The types of clinical reasoning that have been identified in the occupational therapy literature include narrative
reasoning, interactive reasoning, procedural reasoning, pragmatic reasoning, and conditional reasoning (Neistadt, 1996). Narrative reasoning focuses on the client’s occupational story, which reflects the activities and roles that the client values (Clark, 1993; Neistadt, 1996). Interactive reasoning focuses on the client as a person and examines the illness experience (Crepeau, 1991; Fleming, 1991). Procedural reasoning focuses on identifying occupational therapy problems and treatment on the basis of the client’s disease or disability (Fleming, 1991; Mattingly & Fleming, 1994). Pragmatic reasoning considers the treatment environment and the possibilities of treatment within a given setting as well as the therapist’s level of skill and experience (Creighton, Dijkers, Bennett, & Brown, 1995; Schell & Cervero, 1993). Conditional reasoning focuses on continuous modification of treatment to enable the person to function in the future (Fleming, 1991). By using these different types of clinical reasoning, therapists view their clients not only as individuals with physical ailments, but also as social individuals within a context of family, environment, and culture (Fleming, 1991).

Teaching Clinical Reasoning and Case Studies

Students are taught how to apply clinical reasoning methods through a variety of teaching methods described elsewhere (Neistadt, 1996). One of those methods is the use of case studies. Types of case studies noted in the literature are paper cases, videotape cases, simulated client cases, and real client cases (Neistadt, 1987, 1992, 1996; VanLeit, 1995). Different types of case studies emphasize specific types of clinical reasoning more heavily than others (VanLeit, 1995). Paper cases primarily develop students’ procedural reasoning abilities. Paper cases do this by stimulating students, directing them toward issues that must be discovered in order to understand the case and generate solutions. Videotape cases provide students with client information that helps them to develop narrative or conditional reasoning in addition to procedural skills. Simulated client cases provide students with an opportunity to interact with a client, thereby providing opportunities for students to practice interactive reasoning as well as other clinical reasoning skills. Real clients who are willing to share themselves with students promote learning in all areas of clinical reasoning (VanLeit, 1995).

The clinical reasoning case study is a new type of paper case study that illustrates the occupational therapist’s thought processes by providing specific client information under the headings of narrative, interactive, procedural, pragmatic, and conditional reasoning. The cognitive strategy of chunking is often used by experienced therapists to assist with problem solving (Cohn, 1989); this type of case study chunks client information the way an experienced therapist might. Rogers and Holm (1991) stated that explicit detail and many appropriate cues allow the clinical image of a client to become sharper and more realistic. The clinical reasoning case study provides details that yield a clear picture of the client.

The purpose of this study was to determine whether clinical reasoning case studies are more effective teaching tools than traditional paper case studies that briefly list a client’s age, diagnosis, and medical and social history (Neistadt, 1996). The specific research questions examined were as follows: In comparison to traditional case studies, will clinical reasoning case studies (a) increase the quality and complexity of treatment activities selected by occupational therapy students, (b) increase students’ abilities to identify and document the rationales for their intervention plans, (c) increase students’ understanding of the clinical reasoning process, (d) increase students’ level of confidence regarding their intervention planning abilities, and (e) be perceived as better teaching tools by occupational therapy students?

Method

Participants

Six female occupational therapy students of middle or upper socioeconomic status voluntarily participated in this study. All were senior students in the undergraduate occupational therapy program at the University of New Hampshire who were enrolled in a course about adult neurodysfunction during the study period. One participant dropped out of the study because of time pressures, and one completed the research task incorrectly. Therefore, written data from four participants were used for analysis; discussion data were available for five participants.

Procedure

Participants met as a group with the investigator on two separate occasions for approximately 80 min each session. The second session was conducted 1 week after the first. During each session, participants were asked to write an intervention plan that included precautions, problems, treatment activities, and rationale for treatment on the basis of a paper case study. The investigator gave participants verbal instructions to try and include at least two treatment activities for each specific occupational therapy problem identified. For the second session, participants were asked to rewrite or adapt their first intervention plan as they liked. They were allowed 1 hr to complete their plans during each session. At the end of both sessions, after completing their intervention plans, participants were asked: “If this was a real client of yours, how confident did you feel in completing their intervention plan?” Participants responded on a Likert scale from 1 (no confi-
The first session was based on the information given in a traditional case study, and the second session was based on the information given in a clinical reasoning case study. Information for each session was given to the participants 1 week before the session. They were asked to prepare for each session by reading the client information. In preparation for the second session, participants were also asked to highlight any new information in the clinical reasoning case study that they believed important to incorporate into their next intervention plan.

After the second session, the investigator led a 30-min discussion to learn more about participants’ perceptions of their experience in the study. This discussion was videotaped for later review and analysis.

Case studies that were based on clients who have had a stroke were chosen because of the course content the study participants just completed. The traditional case study consisted of information usually found in a chart review, including client’s age, diagnosis, and medical and social history. This information was gathered from the clinical reasoning case studies to ensure consistency between the two case studies. The social information in the traditional case study was organized in a short paragraph, with important facts about the client’s medical history listed after the paragraph. Two different client cases were used to test the difference between case study types across clients. Two study participants received traditional and clinical reasoning case studies about Client A, and three received traditional and clinical reasoning case studies about Client B.

The clinical reasoning case studies were created as a final assignment by occupational therapy students who had participated in an independent study with the first author at the University of New Hampshire. To complete the assignment, participants were given the Clinical Reasoning Case Study Format (see Appendix), which includes questions related to each type of clinical reasoning.

Data Analysis

Qualitative analysis. Qualitative methods were used to analyze data from participants’ intervention plans and their highlighted clinical case studies. Differences in quality between the first and second intervention plans and their rationales were examined. All new information (e.g., new activities, goals) on the revised intervention plans was highlighted. This information was categorized into themes, which reflected the types of information from the clinical reasoning case study that were used in modifying or changing the intervention plans. The ways in which the intervention plans were improved were noted and categorized. The highlighted clinical reasoning case studies were examined for themes in the highlighted material.

Qualitative methods were also used to analyze the videotape for specific themes related to participants’ discussion about their experience with using both types of case studies. This triangulation of data sources (discussion video, intervention plans, highlighted clinical reasoning case studies) enhanced the credibility of the data analysis. Analysis of these data sources was cross-checked to heighten the supporting evidence for the interpretations made (Krefting, 1991).

Credibility was also enhanced through peer debriefing (Hassellkus, 1991). The first and third authors served as expert reviewers or peer debriefers of the themes identified by the second author and offered new interpretation of the data. All authors then collaborated to identify the themes most evident in the data.

Quantitative analysis. Quantitative methods were used to analyze participants’ confidence ratings and the relative number of words highlighted in each section of the clinical reasoning case studies. Participants’ confidence ratings after the completion of each treatment plan were analyzed with descriptive statistics.

The relative number of words highlighted for each type of clinical reasoning represented in the clinical reasoning case studies was determined by word counts. Each participant had one clinical reasoning case study; all clinical reasoning case studies were divided into sections according to the types of clinical reasoning. For each participant, the percentage of words highlighted in each section of the case study was computed by dividing the number of highlighted words by the total number of words in a section and multiplying by 100. Participants’ percentages for the different sections of the case studies were summed and divided by 4 to yield the average percentage of words highlighted for any given type of clinical reasoning.

Results

The results are presented as they relate to each research question. For the first research question, “In comparison to traditional paper case studies, do clinical reasoning case studies increase the quality and complexity of treatment activities selected by occupational therapy students,” the results indicated that the clinical reasoning case studies did increase the quality and complexity of treatment activities selected by the participants. Four main themes were identified from the participants’ written intervention plans related to this research question.

Theme 1: The clinical reasoning case studies provided a new understanding of the client, which resulted in more comprehensive intervention plans. In their second intervention plans, participants added new problem areas to address in treatment because new information was provided.
by the clinical reasoning case study. For example, three participants considered clients' cognitive and functional mobility abilities and added related treatment activities that were not included in their first plans. The treatment activities in the second intervention plans also included environmental considerations, such as “in the hallway” or “in a distraction-free environment,” whereas the plans based on the traditional case study rarely considered environmental factors. Additionally, intervention plans from session 2 included more adaptive equipment than did the plans from session 1.

Participants’ comments during the discussion suggested that the added information in the clinical reasoning case studies helped them create more comprehensive intervention plans:

I don’t know why... I didn’t put functional mobility in transfers [as a problem] in my first list, but I put it in my second. I think knowing all of the information in the clinical reasoning case study made that clear. (Participant 3)

The OT [occupational therapy] evaluation in the clinical reasoning case study also helped a lot because you found out the level of assistance needed or if she was independent. It gave a breakdown of all the problems and all the strengths, more importantly. With all the rationale for evaluation and treatment written out and the evaluation, the clinical reasoning case study gave an incredibly clear picture. (Participant 4)

**Theme 2: The clinical reasoning case studies resulted in more specific, detailed, and individualized treatment activities in the participants’ written intervention plans.** The treatment activities that the participants selected for their second intervention plans incorporated narrative information provided in the clinical reasoning case studies about clients’ interests, values, and goals; this resulted in more individualized treatment. For example, the clinical reasoning case study for Client A stated that she felt strongly about maintaining her personal appearance. In her second plan, Participant 2 said that she would have Client A work on self-care activities such as “washing face, combing hair, brushing teeth, and putting on makeup” and that they would “take the extra time needed for patient to feel good about appearance.” This was more detail than Participant 2 included in the activity plan after session 1 in which she would have had the client wash her face, comb her hair, and brush her teeth but not address makeup or stress the importance of the client’s values about personal appearance.

Another important goal expressed by Client A in the clinical reasoning case study was to maintain her social contacts, friendships, and ability to cook. Participant 1 addressed this client goal while treating the problem of decreased left upper-extremity strength in session 1 focused on the biomechanical aspects of the problem and ignored the social context of the client’s life. Her goal for Client A was to “use left arm/hand as gross stabilizer in dressing and hygiene activities” and that “quick tapping and fast brushing [would be used] to stimulate muscles during activities/exercises.”

When analyzing the information that the participants highlighted in the clinical reasoning case studies, the authors found that information in the narrative reasoning section, which identified the client’s goals, interests, and values, was highlighted the most. Recall that this highlighted information reflects the “new” information that the participants believed was important to consider in their second intervention plan. The average percentage of words the participants highlighted in the narrative reasoning section was 33.8%. This is greater than the averages for the procedural (10.5%), interactive (15%), pragmatic (15.3%), and conditional reasoning (27.3%) case study sections.

The highlighted information in the clinical reasoning case studies revealed that participants considered narrative information to be very important in establishing treatment goals with a client. This was corroborated by the way they used this narrative reasoning information to individualize their treatment activities in their second intervention plans, as illustrated previously. During the discussion, participants identified the following in response to the question of what was the most helpful information provided by the clinical reasoning case study:

...the patient’s interests and her goals, what she identified, that way I wasn’t projecting what I thought was important. (Participant 4)

...all that information, her interests, it helped me to think of different activities that would actually be geared personally for her. (Participant 2)

**Theme 3: The clinical reasoning case studies provided more client information, which resulted in intervention plans that included more active treatment, more “doing” than just “discussing.”** All the participants’ intervention plans revealed that there was an increase in active treatment for the clinical reasoning case study session. Intervention plans for the traditional case study session included treatment that was mostly therapist directed; the client was a passive participant in the treatment. For example, words used to describe treatment activities included discuss, instruct, teach, and look at options with the client. On the other hand, treatment in the intervention plans for the clinical reasoning case study session were more client directed; the client was seen as an active participant in treatment. Words used to describe these treatment activities changed to perform, prepare, practice, and work on with the client.

Word counts revealed that more active than passive
words were written in the intervention plans during the clinical reasoning case study session (an average increase of 33% in active words) compared with the intervention plans written during the traditional case study session. An average decrease of 33% in passive words for the intervention plans written during the clinical reasoning case study session was also identified.

Intervention plans from the traditional case study session may have been more passive than the plans from the clinical reasoning case study session because the participants were searching for more assessment-type information. The clinical reasoning case studies gave the participants the assessment information for which they were searching. The participants could then understand the client's level of function more clearly. Therefore, they were able to focus their energies on explicitly stating what the client would be expected to do in therapy.

Theme 4: The clinical reasoning case studies provided more client information, which resulted in intervention plans that placed the client into a social context. The clinical reasoning case studies seemed to allow the participants to mentally view the client on paper as a "real human being," and participants integrated this "whole-person" picture into aspects of their intervention plans. For example, the fact that the church family was an important part of Client B's social context was revealed only in the clinical reasoning case study. Participant 3 addressed this issue for Client B by adding an activity to "research some religious church groups that she may participate in (e.g., choir, reading scripture to Sunday school class) to increase community involvement." The clinical reasoning case study also noted that social contacts were very important to this client. In response to this information, Participant 3 incorporated letter writing into Client B's intervention, which would allow the client to keep contacts with her friends and family members. This activity was not included on Participant 3's first intervention plan.

During the discussion after the clinical reasoning case study session, participants commented on the holistic picture they received of the client:

...at first [I saw] just an 82-year-old woman who lived alone...[this picture changed] to a woman with 22 grandchildren and just this huge family....I could see her going to church, going to all the different church activities, just really involved in the community. Just a totally different picture. (Participant 3)

I think [having all the information] just shows you that you have to think of everything, every aspect of that person's life and function. You don't just concentrate on one area. (Participant 3)

In summary, the results indicated that intervention plans based on the client information in the clinical reasoning case studies were more comprehensive than the plans written in the traditional case study session. Treatment during session 2 revealed more specific, detailed, and individualized treatment activities and more active treatment. The intervention plans also placed the client into a social context, a context reflected in participants' choices of treatment activities.

For the second research question, "In comparison to traditional paper case studies, will clinical reasoning case studies increase students' abilities to identify and document the rationales for their intervention plans," participants stated that they thought it was beneficial to write their rationales for intervention. Participant 4 stated in the discussion that "writing the rationale...helped [her] to identify why [she] picked the problems [she] picked instead of just throwing them out there."

Participants did not have difficulty identifying their rationales for treatment after the traditional case study session. However, three participants stated that they wanted to remediate the client's skills, but they did not really know how to do this because they lacked information about the client's present status. Participant 1 stated in her rationale for intervention after session 1 that her plan was based on addressing the client's most recent medical problem, a CVA (cerebrovascular accident). There was no information given about a referral or the type or what it would be for, so I wasn't sure how [much] to address other concerns. I tended to think more functionally, especially since no detailed information was given regarding the client's current status, especially with regard to PROM [passive range of motion], strength, AROM [active range of motion], cognitive deficits, etc.

Therefore, participants stated that they used their best judgment when considering the client's abilities and largely based their decisions on the knowledge learned from their occupational therapy classes about the diagnosis given to the client.

After the clinical reasoning case study session, participants' rationales still focused on remediating the client's skills, however, the rationales revealed a new understanding of the client's abilities (i.e., the skills being remediating were tailored to the client's abilities). Participants also added to their second rationales that they based intervention on the client's personal goals and interests and not on their own activity ideas.

For the second session, the participants noted the importance of the client's lifestyle after discharge. Overall, the rationales became much more specific and personalized to their client when participants were provided with the clinical reasoning case study information. These rationales also reflected less "guesswork."

For the third research question, "In comparison to traditional paper case studies, will clinical reasoning case studies increase students' understanding of the clinical reasoning process," participants reported in the discussion that they had never really given much thought to what constituted clinical reasoning. Participant 3 asked...
the investigator, “Isn’t [clinical reasoning] just a process of thinking, right? I never really knew exactly what it was.” Participant 4 stated:

“I don’t think we’ve necessarily learned about [the treatment planning process] in terms of clinical reasoning, but I think we did the clinical reasoning without [knowing] that we were doing it. [The case study] just reinforced the [thinking process]. I have never identified it as clinical reasoning, just the thought process.

All participants agreed with this comment and agreed that they had always just thought of clinical reasoning as “one global thing” and that they never had really understood that occupational therapy clinical reasoning could be explained and broken down by the different subtypes of reasoning. The professional language given to the different types of reasoning—narrative, interactive, procedural, pragmatic, and conditional—was new for the participants. Their comments during the discussion clearly indicated that they obtained an increased understanding of the clinical reasoning process from the clinical reasoning case studies.

For the fourth research question, “In comparison to traditional paper case studies, will clinical reasoning case studies increase students’ level of confidence regarding their intervention planning abilities,” all participants’ ratings of level of confidence increased from 3 after session 1 to 4 (two participants) and 5 (two participants) after session 2. The increase in active treatment activities in participants’ intervention plans after the clinical reasoning case study session also points to an increase in confidence. With a greater understanding of their clients as individuals, the participants were more willing to and confident in having clients “do” rather than just “discuss.”

For the final research question, “In comparison to traditional paper case studies, will clinical reasoning case studies be perceived as better teaching tools by occupational therapy students,” participants commented, during the discussion, on their feelings about the clinical reasoning case study as a teaching tool and about the value of these case studies compared with that of other methods used at the University of New Hampshire to introduce students to intervention planning (i.e., traditional paper case studies, client videos):

I think that I would prefer [the clinical reasoning case study], but I’m used to the other way...if we had these all along, it would be more helpful. I think we were given so much more information and things to go by. We are always searching for things and making inferences, and they could be wrong with the [traditional case studies]. (Participant 3)

It starts to pull everything that we have learned together...especially...the case study that you gave us with the rationale written out and the evaluation...gave an incredibly clear picture. (Participant 4)

I thought [the clinical reasoning case study] was good...because it was so detailed, so you could definitely get all the information that you needed. But I like the videos because we are going to have to do that eventually...evaluating [clients] using [four] observation skills. (Participant 2)

[The clinical reasoning case study] gives you a better idea of what to look for...if the first treatment plan were combined with a video and a case study like [it] would help. (Participant 4)

Participants agreed that the added information provided detail that was very helpful. Participant 3 stated that the length of the cases did not bother her because she would rather have “more information than not enough.”

Discussion

The findings from the three data sources of this study suggest that the clinical reasoning case studies are more effective than traditional paper case studies for teaching students intervention planning. The clinical reasoning case studies increased (a) the quality of participants’ intervention plans and rationales, (b) participants’ confidence in their completed intervention plans, and (c) participants’ understanding of clinical reasoning. Participants also reported preferring the clinical reasoning case studies over the traditional case studies.

The effectiveness of the clinical reasoning case studies may be related to two main features: (a) they may model clinical reasoning by making explicit the thought processes underlying evaluation and intervention, and (b) they provide a holistic picture of the client and his or her occupational therapy treatment. Rogers and Holm (1991) stated that explicit detail and many appropriate cues allow the clinical image of a client to become sharper and more realistic. The in-depth information given in the clinical reasoning case study paints a picture of the client as an individual in a particular social context who has specific interests, values, goals, and abilities. That is, this detail creates a clearer clinical image of clients than the information provided in traditional case studies.

Current literature suggests that occupational therapy educational programs need to emphasize to students the importance of evaluating a client’s values, beliefs, and priorities (Pollock, 1993; Schwartz, 1991). Occupational therapy practitioners’ clinical reasoning should be centered more around the particulars of the person and not his or her general condition or limiting factors (Fleming, 1991). The clinical reasoning case study stresses the importance of narrative and interactive reasoning—thought processes not reflected in traditional case studies. Participants were able to take this narrative and interactive information and use it to enhance their intervention plans, moving from more diagnostic to more holistic and client-centered plans.

Conclusions and Implications for Occupational Therapy Education

The clinical reasoning case study can be used as an effec-
tive teaching tool in occupational therapy educational programs. The case studies can be formulated by occupational therapy students or instructors through the use of the Clinical Reasoning Case Study Format (see Appendix). Educators can use this format as a teaching tool for occupational therapy students involved in clinical experiences. Educators can then use the case studies created by the students as teaching tools in classes where occupational therapy intervention planning for clients with specific diagnoses is taught.

Educators may wish to use these clinical reasoning case studies for a number of purposes. The case studies could be used as a way to organize client information given to students for developing skills in intervention planning, as it was used in this study. The case studies also could be used in a problem-based learning curriculum, such as the one at the University of New Mexico. For example, students could be given client information such as that found in a chart review. When students identify that they want to know more about the client's interests and level of function, they could be given the information from certain sections of the clinical reasoning case studies. Students could then formulate intervention plans on the client. The facilitators could guide the students, using the information in the case studies, by assisting them in identifying treatment problems that they missed. Students could then work on perfecting their plans by making them more comprehensive and having them include client-directed treatment activities. The use of clinical reasoning case studies in conjunction with problem-based and other educational methods needs to be developed and tested further to see whether these case studies have wider applications for teaching clinical reasoning and intervention planning to occupational therapy students.

Appendix

Clinical Reasoning Case Study Format

Narrative Reasoning
1. Complete Canadian Occupational Performance Measure (COPM) interview.
2. Review chart for social history (summarize the social history).
3. Who is this person (occupational narrative)?
   a. What activities and roles have been important to this person in the past?
   b. What activities and roles are still important to this person?
   c. What activities and roles does this person want to be able to perform after occupational therapy treatment?
   d. What activities of importance to this person are now difficult for him or her to do, given his or her disability? How and why are these activities difficult? (You might want to use a chart format with the following column headings to answer this question: Activity, Performance Deficit, Reasons Activity Is Difficult.)
   e. In one to two paragraphs, write this person's story, including an ending about what his or her life will be like after discharge from this facility. Start with, "Once upon a time..."

Procedural Reasoning
1. Summarize this person's diagnoses (primary and secondary) and medical history.
2. List the diagnostically related treatment precautions for this person.
3. List the occupational therapy problems and their corresponding goals
   a. as they appear in the record.
   b. as you would write them (use Uniform Terminology [American Occupational Therapy Association, 1994] language) and be sure your goals are written as measurable objectives.
4. Give a rationale for any differences between your lists in 3a and 3b. If no differences, explain why you think the list in the record reflects this person's needs.
5. List the occupational therapy evaluations delivered or planned as listed in the medical record and the types of information (strength, joint mobility, etc.) gleaned from these evaluation procedures. Also list any other evaluations you believe that you might do with this person if you were his or her occupational therapist and explain why you would give these evaluations.
6. List the occupational therapy treatments
   a. delivered or planned as listed in the medical record.
   b. that you would include if you were this person's occupational therapist.
7. For each treatment listed in 6a and 6b, list the occupational therapy frame of reference you think relates to that treatment.
8. Give a rationale for any differences between your lists in 6a and 6b. If no differences, explain why you think the list in the record meets this person's needs.
9. For one occupational therapy session with this person, observe the treatments given, frames of reference for those treatments, rationales for those treatments, and the person's physical and psychosocial responses to the treatments. (You may want to use a chart format with the following column headings to record your observations: Treatment, Frame of Reference, Rationale, Person's Psychosocial Response, Person's Physical Response.)
10. Would you do this session any differently? If no, why not? If yes, what would you do differently and why?
11. What were the apparent decision points or changes in the session? Why do you think these changes were made when they were?
12. Were this person's short-term goals achieved in this facility? If no, why not? Were the goals unrealistic? Was the occupational therapy treatment inappropriate? Was the person unmotivated?

Interactive Reasoning
1. Describe this person's perception of his or her illness using information from the medical record, your COPM interview, and the person's comments during treatment.
2. Describe this person's interpersonal style.
3. In one occupational therapy treatment session, describe the way the therapist interacted with this person.

Pragmatic Reasoning
1. How long will this person be able to stay in this facility for treatment?
2. What medical insurance does this person have?
3. How many occupational therapists and certified occupational therapy assistants are available to give treatment in this facility (i.e., staffing)?
4. How much time does an occupational therapist in this facility...
have to spend, on average, each day doing paperwork, attending meetings, and providing supervision to staff members or students?  
5. How many clients does each occupational therapist treat each day?  
6. What kind of physical resources are available for occupational therapists in this facility (equipment, space, etc.)?  
7. Does this client have a social support network (family members, friends) who can help provide care after discharge?  
8. Will this person be going home to an accessible environment? If not, what barriers exist in the discharge environment, and what changes would you recommend in that environment as an occupational therapist?  

Conditional Reasoning  
Using no more than half of an 8.5-in. x 11-in. piece of paper, summarize this person's medical and social histories, occupational therapy problems and current status of those problems, and your recommendations for further treatment or other services (e.g., home health aides, homemakers). (This is meant to simulate a discharge summary.)

References  