Date of Interview: Friday October 13th, 2017

Time of Interview: 2:00 P.M.

Location: The interview was held in a lecture room on the third floor of the University of North Dakota School of Health and Medical Sciences building. We positioned ourselves in the kitchen area at a table, where we were across from each other. Artifacts including newspaper clippings and a picture book were located on the table along with our recording devices, a cellphone and iPad. There were no interruptions throughout our interview process.

Transcription

KM: So we just wanna start off with the big picture...what has, what has being an OT meant to you?

JW: Oh, wow. A sense of meaning. You know in our lives, we have to...umm..It's my philosophy..as far as even a spiritual philosophy…you have to..we're here to make a difference in some way and every person has to kind of find out: how am I here to make a difference? And you just analyze your own…your own likes, your own abilities, and sometimes it just comes like subconsciously. I'd never...as think about..oh, I want to be a hospital administrator or anything like that. I don't wanna sit still. I like to move..

KN: Mhmm.

JW: and umm..and the interaction. Initially also, I became interested in OT because of psych. I heard about psych OT..and just my interest in the visual arts and

KM: Yeah

JW: being back then, especially in the 70s and the visual arts and things like this was a big part of OT

KM: You mentioned the spiritual aspect. Umm..what..how would you describe your spirituality? Umm. Do you subscribe to a religion of any sort or just…

JW: Umm. I, myself, you know, I attend a United Methodist Church.

KM: Okay.

JW: But I'm open to other, I don't, you know, put down people who see things differently than I do and I think it's really important for, umm…the religions of the world to kind of acknowledge and respect each other.

KM: I agree.

KN: That's a really good characteristic for an OT to have too.

JW: Mhmm. Oh we must, we must respect each other. Yeah.

KN: Umm..when you..when did you decide to become an..or to be an OT?

JW: I think when I was a sophomore in high school.

KM: Oh wow.

JW: There was an ad on TV called "Careers in Mental Health" and I was interested through, oh, in physical education, you know, we have girls Phy-Ed and we'd have, like, three days a week and then you'd have health class two days a week. And the psych part of that, psychology part of that was really interesting to me. So I sent for this booklet "Careers in Mental Health" and occupational therapy was a part of it. And ironically, the only time I've ever worked in mental health was, you know, psychiatric institute as a traveling OT twice in Anchorage, Alaska, but I was hired to the physical disabilities aspect of that population.

KM: Wow.

KN: That's really neat.

JW: Uh-huh. But psych is so involved in all, in all aspects.

KN: I know, we're talking about that in a lot of our classes...how important that is to address in the phys-dys, physical disabilities setting.

JW: Right. I'd heard that, for instance, there, that 30 percent of people with a physical disability have some kind of psychiatric diagnosis, like depression or whatever. And about 30 percent of these

psychiatric patients have a physical disability of some type.

KM: Wow. They go hand-in-hand I guess.

JW: I, I, umm, heard that at this, four times I went to, umm, we call them workshops, which they don't have any more at the National Institute for the Clinical Application of Behavioral Medicine and that was very into mind-body-spirit interactions for physicians. They had all kinds of people there: physicians, OTs, PTs, umm, nurses, respiratory therapists,

KM: Mhmm.

JW: Massage therapists, all kinds of people

KM: Okay.

JW: So a lot of really good people there. And that's where a psychiatrist was talking and talked about the 30 percent and the 30 percent.

KM: Okay, wow.

KN: So that's how you found out about the profession was through school at the career services?

JW: Umm, it was an ad on television.

KN: The ad on television.

JW: And I sent for a booklet for careers in mental health.

KM: And why did you choose physical disabilities, umm, over any other setting?

JW: Okay, well umm, all throughout school I thought I was meant to be in psych because that was of interest to me and the other courses I was just taking. Then I got on my student affiliations. My student affiliation for psych was really quite disappointing because it was keeping the people busy. And then when I got on my physical disabilities, it was at the Houston VA during the Vietnam War and it felt like I was really, really using my background…

KM: Mhmm.

JW: …and I thought, I'll start out in physical disabilities and I can always switch to psych later.

KM: Yeah.

JW: You know, it was an easier way to go, and I just ended up staying in, in physical disabilities.

KM: Wow. And look where you are now. Working with Parkinson's patients. Like, that's awesome. So what… you mentioned traveling OT…what… how did you get to that point of wanting to do that?

JW: Well, the first time I did it was umm…after I worked in Fargo.

KM: Mhmm.

JW: They said that they were going to have some…well Jan Stube was my supervisor, my immediate supervisor then.

KM: Really?

KN: Oh, she's so sweet.

JW: Yes, umm, and then Diane Kaiser was the head of that. And then they thought they were going to have some kind of cutbacks. And they said we aren't going to cutback any one person, but people might be asked to take vacation days or something, you know, in order to keep our productivity up. And then one of the OTs had just come back from being a traveling OT and liked it and I thought, I don't really want to take vacation days when I don't want to. I'll just, you know, it was a good time to just quit and be a traveling OT. So then I had assignments, umm, in North Carolina, Durham, North Carolina. And then a long eight month long one in Tuscon, Arizona. And then after that, I went back to being, having stable jobs again, and starting with a COTA, umm, teaching COTAs in Montana and things like this until at a certain point, at age 59 and a half, I, umm…left Altru permanent position, became a traveling OT again, but came back to Altru to do fill-in when I wasn't traveling. So I've done traveling OT two different times in my life.

KN: Did you really enjoy the traveling?

JW: Oh yes, yes. It was, it's very, very, very enjoyable. It's like, you know, you work, you meet other people, you're in another part of the country, and you can really get to see another part of the country.

KM: I know we're both very interested…

KN: We're kind of interested…

KM: in traveling OT so that's why…

JW: Oh okay.

KM: That's why we decided to ask that question.

JW: Mhmm. You have to be..umm..very careful, umm just, in you know, ethics. The AOTA has stated that too. You're probably aware. And I had given Jan Stube, umm, a disk I believe that I had ordered through AOTA talking about, you know, just making sure, because if you're working for a company that's…their main emphasis…they want to be, they wanna make money. You have to be ethical in making sure that the patient is really benefiting from OT rather than just having the main emphasis be make money for your company.

KM: Exactly. Being more concerned about the person rather than productivity levels. Yeah.

JW: Mhmm, right.

KN: How do you see the profession evolving over the time of your practice?

JW: Wow, I was just writing some things down about that. And I'll just take out my, my little list.

KM: You came prepared.

(shuffling papers on table)

JW: Okay, one thing, for instance, over when I started working at rehab, length of stay is a big difference. We could keep patients a long, long time. Stroke patients, five weeks was very common. Spinal cord injuries, six months. Three to six months.

KM: Wow.

JW: Yeah. They would just stay. The people would stay until the doctor said you can be discharged. And the third party payer would just pay for that.

KM: Wow.

JW: Now there's a lot more emphasis on you must, you know, be able to show the third party payer the patient really needs inpatient or that he's progressing with his outpatient, so that's… Also, we had like about a five percent write-off. They said, at rehab, like where people just didn't have the coverage, we would just keep working with them anyway. So that's a big, big difference. Umm…Notes, documentation. Oh, when I first started working, there weren't really any rules as far as how often you had to document on the patient.

KN: I bet that was kind of nice.

JW: Oh yeah. Early on, they said, okay, you must have a note every two weeks and that seemed like, oh wow. And the notes then, we started out with, I don't know if you know SOP or SOAP.

KM: Yep. SOAP notes.

KN: Oh, yep.

JW: And we didn't end plan. Nothing, it, things weren't specific. You didn't have to have very specific goals like, you know, patient is now at just upper body dressing with moderate assistance has progressed to minimal or, you know, whatever…by next week or whatever. Things, umm…you know, the goals were much more broad…

KN: Okay.

JW: …and allowed us to keep on seeing the patient longer and there's a lot more emphasis on goals, as far as fulfilling goals. You know, working on specific goals, such as activities of daily living than previously. I could, previously, you know, just said that I want to improve his range of motion. Active range of motion. Or whatever.

KM: Yeah.

JW: And that would have been okay. It's not okay now.

KM: Not anymore.

JW: So, the uhh, the meetings. For instance, now you have a meeting on, in acute, you'd have a meeting every day on the patients with the staff there. Umm, originally when we started working in 1970, the occupational therapists met once a week in our own office with Dr. Barkum, and he was there…to answer…the physiatrist, was there to answer questions.

KM: Okay.

JW: And that was basically what it was. It wasn't, you know, like how is he doing on ADLs, how is he doing, or you know, like how is he doing different goals and things. So, those were different. In some ways, we've got a lot better at staff interactions now because of staff meetings and different…umm..with that way. Okay, specialization now, when I first started working at rehab, everybody worked adults, pediatrics, hand therapy. We all did everything and now there's much more specialization…

KN: Oh yeah.

JW: …because there's so much more knowledge. Even, umm, for instance, the hand therapists, uhh, when we post-hand surgery, the orthopedic surgeon would just tell the occupational therapist directly what to do rather than having to have the therapist knowledge of what to do.

KM: Wow.

JW: And now the OTs, know, they know how to do that.

KM: It's totally changed.

KN: Yeah.

JW: It's totally changed. And also, pediatrics, I was comfortable doing both, the, all the areas like pediatrics and adults because I'd just gotten out of school so we knew all the different areas. You know,

aging errors, the different methods and things like this. As the more...as I progressed on in therapy with years going by, there's no way I would have been able to just bounce back and forth. There's just too much knowledge, much more knowledge in each area.

KM: Yeah, there is.

KN: That's for sure.

JW: So specialization, umm, as I mentioned the splinting materials, how that has gotten, you know, technology…and starting with Johnson & Johnson and orthoplast and all these other…aquaplast, and all the splinting materials really make a difference. And even pre-fab or wrist supports and things like this. Umm..another emphasis…it's way different is…occupational therapy in acute. When I came to Grand Forks, there were no occupational therapists working in acute. Rehab was separate, it was on campus in the, in the, you know, old rehab building across from the student union. And then of course, the St. Michael's and Deaconess hospitals. After I had worked a few years, I know we had a woman come in…from…she came to Grand Forks. She'd been a UND student but then was working in Minneapolis in the burn program but then moved to Grand Forks because her fiancé was a law student. And she was the first one then, Carol Tuminelli Hegland, was the first OT to work in acute.

KN: Wow.

KM: Wow.

JW: You know, she had problems and frustrations because physicians didn't know what to expect of…of an OT in acute. And I know that early on, even when I was in school, there wasn't that much emphasis at all in acute. It was almost more like, keep somebody busy.

KM: Yeah.

JW: That type of thing. Whereas now occupational therapists work closely with physical therapists to get the patient up out of bed early, the emphasis on being in an upright position to prevent other conditions

and just a lot of… a lot more emphasis for OT in acute now.

KM: Yeah.

JW: And the patients come to the rehab much sooner. I remember when I first started working…umm…after a few weeks, we were just shocked because there was a stroke patient who was coming to the rehab who was only 5 weeks…no, he was only 5 days post. And we thought, oh my goodness, only 5 days post, and uhh…his stroke. But now people get out of the hospital right away…acute care come to rehab really soon. And that makes a difference in the nursing staff too. The nurses have to be much more able to provide…rehab nurses much more able to provide acute type of care.

KN: Absolutely.

JW: Umm let's see. There's much more use of skilled nursing facilities for OTs now…umm, skilled nursing facilities, for instance, umm…we used to be something a person was sent to, kind of an end-stage type of thing.

KM: Mmm.

JW: And now…it's…they're, they're so specific on who can be in the rehab, you know…again, rules made up…made by third party payers, this type of thing. Saying what conditions must be for the person to go to the rehab. And many people aren't ready to go from acute to home but they don't qualify for rehab so then they can go to skilled nursing facilities. And I've worked as a traveling OT, I've worked in several skilled nursing facilities and, and it's really…it's a good place as far as the goals can be very similar to working in rehab. Maybe it's somebody who can't quite tolerate three hours of therapy a day but you get him up to that so maybe he can go to rehab or go home.

KM: Okay.

JW: So that's…that's another…also, as I mentioned before, society in general is much more into mind-

body-spirit and so that emphasized…umm, it brings in OTs a lot more. I know at Altru, for instance, doing…in, in Fargo, St. Luke's Merit Care…which was in St. Luke's Merit Care, there…was using such things as, you know, a lot of…oh, umm...I'm blocking on it…smoothing out the meridians, and things like this…umm, an emphasis on other cultures too. I think there's more acceptance, for instance, like in East Grand Forks where you have…oh, an acupuncture…an acupuncturist…And that's difference in society, accepting these things…and in medicine…or even, I think about the difference…oh, chiropractors were previously so looked down upon so much and even fifteen years ago, I know my cousin's husband, who was an orthopedic surgeon went to a conference in England. And he said one of his lectures was appropriate referrals from the orthopedic surgery to go to a chiropractor…and one was tennis elbow. And you would never hear about that…physicians going to a conference hearing about appropriate referrals to a chiropractor.

KN: Right.

KM: Mhmm.

JW: Or more recently, I know of a woman who said that her physical therapist in Grand Forks referred her to a chiropractor. So there's just much more integration and umm…you know…cautious respect between different types of backgrounds.

KN: Right.

KM: That's good though because it brings more diversity to treatment. More options.

JW: It really does. And when you think about, you know, acupuncture being used, umm…by the Chinese for many, many years…they wouldn't keep using it if there was nothing to it.

KM: Right.

KN: Exactly.

JW: So society, so that's basically the changes I've seen through, through that.

KM: Alright.

KN: Thank you.

KM: So we wanna look at the context of practice when you graduated…and what was going in the world, maybe socially, politically, economically, anything like that…

JW: Okay, umm, in the world…When I was doing my affiliation..my physical disabil…physical disability affiliation, of course, the Vietnam War was going on, so in my physical disabilities affiliation at the Houston VA, I was seeing a lot of men who were in my own age group who were severely wounded, you know, double amputee…double lower extremity amputees, head injuries, umm..yeah, very very sad. I think a person always identifies with the patients who are mostly…closely, closest to your own age group.

KM: Yeah, like that could be me.

JW: Mmm. Yeah, yeah…or a good friend. Yeah.

KN: Right..umm..thinking back on your career, could you tell me a little bit about…or reflect on your personal growth and your professional development?

JW: Okay, I think that one important aspect of it was when I went to an NDT certification course in 1985. That brought me a lot of new treatment ideas for the stroke and head injury patients…and it worked a lot with the stroke and head injury patients. Another thing that helped a lot was when I worked in Fargo, I was on the head injury team, and it worked very…the team worked very closely with the neuropsychologist and we learned a lot about different…umm, they talked about different levels of attention and dealing with the patient at this level of attention, this…and upgrade and upgrade and upgrade. So that was something new for me also.

KM: Wow.

KN: So that really made an impact on your…

JW: Mhmm.

KM: …professional...

JW: Yes, and that was a team approach and I think it's very sad that, umm…neuropsychologists are not on, every, you know…aren't full-time in every rehab now.

KN: Mhmm.

KM: Right.

JW: You know it was something that was cut out and I think it's very, very tragic.

KM: Yeah, because it's the brain that has an issue and it's the brain that needs to be addressed.

JW: Mhmm, mhmm.

KM: So do you…umm…have any personal accomplishments that really stand out to you, uhh, in the field of OT?

JW: Hmm. Personal accomplishments…I taught in an OT assistant program in Great Falls, Montana.

KM: Okay.

JW: And that was, uhh, something that I think hopefully that I taught other people…

KM: Yeah.

JW: …and helped the COTAs become good COTAs hopefully.

KM: That's awesome. Yeah.

JW: And I just think, that when I first went to the certification course for NDT, uhh, that was in California. And as I said, in about 1985, and I was able to come back and teach other OTs about the NDT methods and I also started to…uhh, a program came in at night to do bed positioning and I taught the nurses how to do bed positioning.

KM: Okay.

JW: And I know one nurse who's still…she's a retired nurse now, Bernelle Bachmeier, who was,

umm…a charge nurse at night and she was very, very receptive and wanting to carry that out…and did. And she later told me that when she was doing bed positioning…NDT bed positioning that she'd learned from me…a patient said to her, Bernelle can do…wrote in his assessment of the stay…Bernelle can do more with pillows than other people can do with pills.

KM: *laughter*

JW: It's just kind of interesting.

KN: Very.

KM: That's awesome…Let's see…

KN: Was there something that you'd like to do but weren't able to accomplish throughout your career?

JW: Hmm..umm..in a way, I wish I would have kept on working longer. Umm, a person, uhh, I worked till age 65 and a half and you work until you injure your knee or your shoulders or whatever..

KN: Right.

JW: with…through physical disabilities. In a way, I think I could have worked a little longer.

JW: Or I thought about at one point, I thought I should do something overseas internationally.

KM: Oh,wow.

JW: But I didn't really find anything and I looked at contacting other people. I really didn't see anything, nothing really sprung up for working overseas.

KM: That seems like it would be an adventure.

KN: Yeah.

JW: Yeah, I think that when I was, you know when you talked to me about what was going on and what was happening when I was working in the 1970's, Peace corps was big and it's not really that big anymore. I don't know if OT's are being recruited or seen as being valuable for that. I think that there is a lot of things that OT's can do in throughout this world. The world is so en-dangerous now that it is harder

for a younger person to in your age group to think about going to another part of the world to make a difference.

KM: Yeah, definitely. There is a lot going on.

JW: When you talk about my accomplishes too, I have done a great deal of international travel. A couple of the times its been OT related and one time I went with some OT's from the University of Mary to Guatemala and they were doing um, ah we built a simple house plus we went to some different places and helped out. We went to some different orphanages and helped out there as well.

KN: Oh wow! I bet that was a really neat experience.

JW: Yeah, ah-ha, it was really fun.

KN: What is one of your best memories of being an OT? If you can pick one.

JW: Oh wow, there are so many.

KM: Kind of a loaded question there.

JW: I think just early on, how OT when I first started working, rehab was the only place rehab in the state. Plus western Minnesota so we would have patients from all over. And I just that being able to treat those patients or even this patient that was written up here, here's a picture of me with him. And this was on his company, he worked for a coal company and he had a brain injury. And his company, this isn't a medical thing, it's editorial speaking from his coal company in center North Dakota and how they came and they took a picture of Fred with me and this treatment. So early patient

KN:That's really neat.

KM: That's so cool.

KN: And that's you right here?

JW: Yes.

KN: Neat

KM: Wow.

JW: Yeah, I think early, early stages when we were rehab, like I said, it was so unique in order to helping people. Lots of people.

KM: Wow.

KN: That's awesome.

KM: That's so cool to see the transformation. That's awesome.

KN: Has there been a patient that has left a particularly big impact that you can remember?

JW: Yes, I think maybe the early on people were. There was this one person, David Jelmahog, and I dont think its a problem that I'm just stating names. He was. When I first started working and again and I think when you are first starting to work you are so much more impressionable. Things just impact you a lot more than Oh, I've been doing this for years. David had been hit in a car accident, he was from Jamestown, hed been working as an engineer for Kodak on the east coast, in New York. Um, upstate New York I believe, he'd been in an accident and a drunk driver had hit his car and for his rehab he had come back, closer to where his family was here. And he progressed so well and he went on, after he left, when he'd been gone for a month. He sent a bouquet of flowers to his PT, and to me in appreciation.

KM: Oh wow.

JW: And just as he went on, was able to go back to work, um, married, you know all these experiences, you know going from being a rather severe involved head injured patient to progressing that far. And at this point he's a facebook friend of mine. This many years later and that was probably like, 1971 and he doesn't post that much on facebook that often, but enough that I know he's doing okay.

KN: How he's doing.

KM: Oh wow. That's awesome that you've been able to keep in touch.

JW: Yeah.

KM: That's so cool.

JW: Yeah, we don't keep in touch lately, but anyone can look up anyone's name.

KM: Exactly.

JW: A few years ago he did, and said do you want to be my facebook friend and I said yes.

KN: Awww. That's really neat.

KM: That's cool.

KN: For sure a rewarding profession.

JW: Oh yes, ah-ha, yes. Yes.

KM: So, you've told us kinda about like the good memories, do you have any, say challenging things that have gone on in your career, that have stressed you out, or just really have been difficult?

JW: Challenging things, let me see, um, what would I say. I think it's always important to explain yourself well and what your ideas are and think that sometimes that if I ever had any problems maybe it was because I didn't explain myself well enough and what I was doing. And I also think that you need to, if there is some potential problem, um, seek assistance immediately. And I think keeping quiet and not seeking assistance soon enough can, um, can create problems that you could solve. Could be solved earlier.

KN: So collaboration with the client is a very key aspect.

JW: Collaboration, right. Explanation, collaboration, ah-ha. But I think that in my own mind, I think that I've always enjoyed working because I can think of good things, I feel good about every job that I have had. And I have told myself that before and that's because I, I know when to leave. I had this intuitive feeling of when to leave. And that's helpful. You need to know, just trust your own instincts. Where can I serve better somewhere else.

KN: Right.

KM: Note to self. Know when to leave.

KN: Know yourself and the situation.

KM: So, did you ever experience any kind of like stress from maybe not seeing your patients progress the way you thought they would or wished they would.

JW: Hmm. Stress, I think there is an understanding that not everyone is going to progress. You do all that you can do, you do the best you can do, and.

KM: That's good that it doesn't weigh on you it sounds like.

JW: Mhhm.

KM: Okay.

KN: After, um, just like if you had a stressful day at work how did you relieve your stress?

JW: Physical, I think it's good to do physical things, I like to do a lot of walking.

KM: Okay.

JW: Ride a bike, I love walking on campus for much of my life when I've lived in Grand Forks. I've lived near campus. Cross country skiing, I think things like this.

KM: Wow, you're really active.

JW: Cooking from a recipe. Those types of things.

KM: Awesome.

KN: I know you said that you or you traveled all over, how long have you lived in Grand Forks?

JW: Well I've lived, as you can see from my resume, I came here first in 1970 until 1977. Then, I left a few times and came back a few times. It seemed as though, Grand Forks is my home. And any place else that I've been, it's been a place I have lived for awhile. So, um, just on and off since 1970 I've lived in Grand Forks.

KM: Something about Grand Forks that holds you back in.

JW: But, ah, I've lived in um, for instance, the first time I left, I went to Atlantic City for a couple of years. I worked in a children's rehab there, and then Minneapolis for you know a few years. Um, then Grand Forks for several years. I've lived in Minneapolis. I've lived in Great Falls, Montana as I mentioned when I was teaching as an OTA instructor. Um, different places of traveling OT, I have loved working different places. I loved traveling to northern California as a traveling OT.

KM: Oh, wow.

KN: Ah..

JW: And I loved Ancrage, Alaska as a traveling OT.

KN: Ah.. I bet that was fun.

JW: I went there twice and again that was a psychiatric setting where the patients needed someone working in physical disabilities, and that's where it really shows that you know with a stroke patient, you can't just say, there going to, they don't need therapy anymore. Because I would see patients in the psychiatric, I can think of two different stroke patients in the psychiatric division who had been, had a stroke years ago, and maybe they were indigent people who didn't have as much therapy as they should have initially. But even, years later, seeing good improvement. Probably because we were relaxing the muscles more, rather than, you know more actual messages returning, but no, we could see return in people who hadn't had therapy in for a long time.

KM: Wow.

KN: That's neat. I know you went to University of, you went to Kansas for your education, um, would you mind telling us a little more about your educational experiences.

JW: Okay.

KN: Such as the class size, any theoretical models that you used.

JW: Okay, we were, ah, I think there were about twelve in my KU class.

KN: Oh, wow.

JW: You'd have your pre-OT class you know, and then um, at KU we stayed on the main campus until our last semester, which was then the medical center in Kansas City. And then when we went to the medical center in Kansas City, we had OT instructors, but we also had people who were resident physicians who would come in and talk to us about their own, um, own specialty area and how they saw OT fitting in. So that was really good, ah-ha.

KN: How long was your program?

JW: Ah, let me see, four years of college and ten months of hospital training. Ten months of affiliations. We were required to do four affiliations in all the different areas. Three months in physical disabilities, three months in psych, and you could do the psych one the summer before your senior year, two months in pediatrics and general medicine and surgery.

KN: Oh, wow.

KM: With that amount of schooling did you feel prepared going into the profession.

JW: Yes I did!

KM: Awesome.

JW: Yes I did, the um, but of course then everything, you know, there weren't many specializations. There wasn't as much knowledge in each area.

KM: That's true.

JW: As I mentioned, like hand therapists, orthopedic surgeon would just tell us what to do

KM: Yeah.

JW: Now the hand therapists have to know, um, there is so much more knowledge in each area now than there was when I was a new OT.

KM: So, okay, wow. That's so weird to think, because we have to go through three additional years, plus

our bachelors degree in some cases.

KN: Did you have any prerequisites that you had to do prior?

JW: Oh, yes.

KN: Plus the four years or was that included in

JW: That was included. You'd have two years of prerequisites and then you'd be accepted into the OT program that would involve the next two years, plus your affiliations.

KN: Oh, okay that makes sense. Thank you.

JW: So about, it was a five year program.

KM: Okay.

KN: Okay.

JW: Okay, so um, like say, it worked out well for that time. Pediatrics I did, it was called, um, crippled children's nursery school in Kansas City. Um, as I mentioned, physical disabilities three months in the Houston, VA. Psychiatric three months in St. Mary's in Minneapolis. And, um, I did general medicine and surgery which was called general medicine and surgery but it was actually more like a skilled nursing facility for two months in Hawaii. In Hilo, Hawaii.

KN: Wow.

KM: Wow.

KN: What states haven't you been to?

JW: A lot of things like this have been very, very fun.

KM: How do you feel, um, about the OT profession moving towards a doctorate degree?

JW: Well, um, I think that it makes it very expensive for the OT students.

KN: Yeah.

JW: I know that, when I was a traveling OT, in Omaha, the woman that was in charge of the program,

she was a graduate of Crayton, and had a doctorate. She kept saying I got 80,000 dollars in college loans and got 80,000 dollars in college loans. Maybe Craytons more expensive than UND, but you know she was out of school for a couple years and was a chief their.

KM: Wow.

KN: Wow, it's a spendy process, that's for sure.

JW: Mhmm.

KM: As far as the knowledge gained and experienced with a doctorate, do you think it's worth it to move it to a doctorate or do you think that you'd be prepared with a masters or bachelors degree?

JW: I think a master's is a good idea. I think a master's is enough and just have people start working and then really encourage continuing ed following in that.

KN: That's the really important part.

JW: In the area that you're interested in or if you wanna change areas, ah-ha.

KN: Right.

KN: So you see the more, the drawback is the cost.

JW: The cost and the, I think there is only so much you can learn before you start applying it.

KM: Yeah.that's true.

KN: Absolutely. That's for sure. Ah, North Dakota/Wyoming are considered to be a rural state, how did this influence your practice?

JW: In rural state, um, as far as when I first started working, of course, ah…, we kept the patients a long time in rehab as I mentioned. I think that was because it was so far for them to be from home if they were from Dickinson. For instance, I remember we had a young head injured woman and she was probably 22, who had fallen off her horse, head injured from Dickinson, she stayed a long time. There wasn't OT available out in the Western part of the state. So early on, that really made a difference.

KN: Now OT is pretty prevalent in just even, smaller towns.

JW: Mhmmm, mhhhm.

KM: So you mentioned continuing ed, um, what kind of continuing, continuing, education courses have you attended, um, in your career?

JW: As I mentioned, that the um...the um...NDT certification was three weeks long..

KM: Yeah…

JW: In locatus, California. Four times, I went to a week long conference, this one the national conference, um, called Nickibomb, the international institute for the clinical application of behavioral medicine, or mind, body, spirit. Um, this is still a website if you ever wanna look things up on it. They have a, um, it was a wonderful conference and you'd see people, it was in hiltonin head, North Carolina.

KM: Okay.

JW: And, ah, you'd see people all over the world, especially the first time I went. Then the crowds were getting smaller and smaller and smaller because I think as the, more and more clinical education is available online, and less and less money for employers to travel. Like I paid for my own expenses.

KM: Oh, wow.

JW: But it was worth it to me.

KM: Wow.

JW: Um, the, unfortunately there was less, you know, less out there, continuing education. It is more and more online. You can, if you look this up, you can get some, um, free information too, but, just again… there is one man who spoke, I'm blocking on his name too, Peter, ahhh, I'll think of it sometime. He has been given the um, the AOTA, um distinction.

KM: Okay.

JW: And he has spoken there sometimes.

KM: Wow.

JW: And I really wish that this, um, you know, that they had reached out more to OT's specifically for their people, I don't know if any of the OT's knew about this.

KN: Mhmmm, right.

JW: I think they could have had a lot more people attend, maybe not having to close down and say we aren't going to do this anymore.

KM: Yeah, that's a bummer.

KN: Have you ever attended any of the national conferences?

JW: Yes I have, um, I attended one in Minneapolis and one in Seattle, Washington.

KN: Oh, I bet that was fun.

JW: Oh, yes, ah-ha.

KM: What years were those in?

JW: Let me see, oh-ah, Minneapolis probably about 1986, I think. Um.. Seattle, maybe about um, 1992.

KM: Okay.

JW: I believe, I can't say for sure.

KN: What did you think about those experiences?

JW: Oh they were good, they were very good conferences. Mhmm. Learning to just, ah, different areas and just seeing OT useful all over, all over the country. I think that it was just a very, very good experiences. When you talked about, about different um, workshops, also one, some people that gave a workshop that I've seen twice at workshops were um, they now live in Australia, two OT's who now live in Australia, they gave a lot on sensory integration.

KM: Oh, cool.

JW: Yeah. So um.

KN: That is really interesting.

JW: Mhmm, right.

KM: We have learned a lot about sensory integration in our classes.

KN: Oh yeah!

JW: Mhmm, and I will think of their names sometime too.

KN: So, um, moving onto our next question, Imagine that we were a family members who are considering a degree in occupational therapy. What advice would you give us?

JW: Okay, I would ask you, to ask yourselves why do I want to be an occupational therapist. And see what you tell yourself. Maybe, maybe write some things down, cause you can think things through better when you write things down, the pros, the cons, what you think you have to give to one career and what you could give to another.

KN: Right. That's very important. What have been the positives of being an OT?

JW: I think um, oh…. The satisfaction of being able to help people, the ability to engage in continuing ed and to have oh, background to know why you are doing what you are doing. Um, the ability to have jobs in different places of the world, such as traveling OT's.

KM: Yeah.

JW: And just, um, I think being able to treat the whole person, like mind, body, spirit.

KM: Yeah.

KN: This is kind of off topic, well kind of but relevant, what kind of theories did you use, models, and frames of references did you use while practicing as an OT?

JW: Okay, um, but I was in school early on when I was working in pediatrics, Dr. Josephine Moore, was big. Are you still learning Josephine Moore?

KM: I don't think we have learned about her.

KN: I don't think so.

JW: Okay, she was from way back, she was um, she was very big if you were an OT in the 70's, earlier, she was Dr. Josephine Moore, PHD, she did a lot with children and did a lot with reflexes, she would consider the reflexes a lot more.

KN: Maybe that name sounds kind of familiar.

JW: Dr. Josephine Moore, you'll have to look her up.

KM: Maybe we've touched on her in class, yeah we'll have to look her up. Um, have you ever had any experiences with, um, with theories like cognitive behavioral frame of reference, or MOHO, have you ever heard of any of that stuff?

JW: Cognitive behavioral theory I have heard of.

KM: Okay. Yeah, um, they have introduced a lot of theory that guides the practice and um sort of a newer thing that we were wondering if you had any experience with. Maybe the model of human occupation, have you heard about them?

JW: Of course model of human occupation.

KM: Okay, so you know and are aware of that. Do you employ any of those theories in your practice?

JW: Um, I have been retired since 65 and a half.

KM: Im sorry, I meant did you.

JW: As far as thinking specifically about the, for instance the cognitive certainly. As I mentioned, we worked with a neuropsychologist from Fargo, if this is what you were thinking of, they looked at different attention levels, um, those theories employing that.

KM: Yeah, mhmm. Awesome.

JW: And of course the theories in NDT, MOHO, now I have seemed to hear about that, could you tell me specifically what that is.

KM: Yeah, so it's um, basically a conceptual model that drives interventions and looks a lot at motivation, um so they bring in the person, environment, and occupation how the person thinks they are performing versus how they are actually performing. And it kinda, yeah just drives, I don't know, the interventions and changes.

KN: Yeah, it kinda has the evidence behind what you are doing.

KM: Were kinda just learning those, so it is kinda hard to explain.

KN: A little rough on the edges there. That's just a general view.

JW: Okay, okay that is very good to know about and to think about the persons himselves, what does he want, is it important to him to be able to dress himself, would he rather have somebody else help him to have time for other things.

KM: Exactly. You're getting it better than we are.

KN: You probably are using it and you don't even think about, ohhh, I'm doing MOHO. It's just more natural.

KM: You don't have the name to it.

JW: Certainly we had in, during the years of practice, think about what are the patient's goals, things have to be more patient centered now. Especially deciding, we are working for the patient, we aren't there to push them to do something.

KM: That's true.

JW: He decides the goals and we help him to establish those.

KN: Right.

KM: Yes, all about person centeredness. Alright, so we can do this little card sort activity, um, so we have this little list for you and this is for you. If we were to have time we were ask you these, and we do have time. So, we want to ask you to look at this list, okay so, starting at number one going down to

number ten, the list of theses things. And we were wondering if you could order those on levels of importance.

JW: Levels of importance to me? To occupations?

KM: Um, to occupational therapy. Which do you think are the most crucial in, in implementing?

JW: Okay, um I'll label continuing education is very important. Activity analysis. Team, team is certainly important. Ah, legislation, as medicare, medicaid, rehab, public law. Where does public law 9192 mean?

KM: I'm not sure.

KN: You can just scratch that one out.

KM: Yeah, I don't know, you can just scratch that one. Cause, we haven't learned about the um, laws yet this semester.

JW: Okay. Occupation being the broad term?

KM: Mhhm. Awesome.

JW: Okay.

KN: Thank you.

JW: Ah-ha.

KM: Now we just have a few questions about those. Why, um, did you prioritize them the way that you did. For example, why did you put continuing education first?

JW: I think it's really important as far as um, from my aspects, for instance, I started so long ago that I really needed the continuing education and or to keep up and know what's and what is available. There is no way I could work now with the amount of knowledge that I had in 1970 and do a good job.

KM: Yeah.

KN: And the profession just continues to grow more broad too and there are always something new

coming out, research, everything so, that makes sense why continuing education would be a very good top priority.

KM: Um, could you tell us a little bit more about why you put arts and crafts as the least out of the ten?

JW: Um, just because, for instance when I first started working of course you'd have a whole course on mind and crafts. Do you still have that in school now?

KM: We don't.

JW: Okay, we had to analyze the craft, do, learn how to do the copper tooling, and we even had a whole course on weaving.

KM: Wow.

JW: Knowing how to thread the lume, the whole works.

KN: Right.

JW: And you know, that's why it just isn't used that much anymore, it's short term positioning and short term hospitalization. The arts and crafts are just not used that much anymore.

KM: Right.

JW: Even in society, I don't think people you know, in previous years when people were homemakers, there just weren't as many people in other areas. Arts and crafts were more important to the general public, maybe. Years ago, when OT started. Um. it's not important to do specific arts like copper tooling, just find out what your patient likes. Make sure you can do that.

KM: Exactly. It's good to see you rated occupations above arts and crafts because it's certainly what the patient wants to do, above just arts and crafts. Unless, of course, arts and crafts are what the patient wants to do.

KN: Thank you for sharing those. So, on a closing note, I know you continue to volunteer, do you miss doing OT from when you retired to now?

JW: Oh yes, I still miss working.

KN: So you are still doing volunteer opportunities, it kinda.

KM: Kinda fill that void.

JW: Yeah, it is like you say, having a sense that you're contributing to society.

KM: Yeah.

JW: But I can show you, just quickly in case you…

KM: Of course, we have time.

JW: These are pictures of when I was in OT school, like I said, doing the splinting with, just the bandaids you'd use the plaster bandages you'd drop into the water, that kind of thing. The OT students just in our room. But, um, here's our OT class.

KM: Wow.

JW: Again with the splint, sometimes you'd make plaster cast of the patient's arm and make the splint on it, you can imagine how time consuming that was. Now these were not, ah, let me see, just gonna go ahead and show you some other OT things. These are some OT early on, OT's that worked at Rehab. And this is in our rehab, the balls, for pediatrics, the big balls.

KM: Wow.

KN: Is somebody in that ball right there?

JW: Um, people could go, children could go inside the ball.

KN: Oh, that is neat.

JW: Did you ever see or use those big barrels, big cardboard barrels that were lined with carpeting inside and out?

KN: I think I've seen what you're talking about, something like that.

JW: Yeah, that was used a lot for sensory, for vestibular input, and the ball is for balancing, people sitting

on top of them for balance. Or having a little kid lie on their belly on the ball and then bring them forward for that extension, although being careful with their reflexes going back.

KN: A lot of purposes used with those.

JW: Let me see here, ah.

*Began looking at artifacts; conclusion of interview.