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I: Right. Okay, so you got the participant information.

R: Yes, yes.

I: Are you happy with that?

R: I’m very happy to part of this research.

I: Okay, that’s excellent. Thank you. So, can you tell me about your clinical postings on your course?

R: You’re asking from the first year, no?

I: Yeah.

R: So, clinical posting for in health profession goes, like, our occupational therapy, it is very essential for students, especially undergraduate students. So, basically, first year. On all four years, our profession is four years six-month internship programme. In the first four years, we should have some clinical exposure. The first year, the main thing is to observe what a Therapist do and how he creates a rapport with the patient. That is the first year experience, that is the first – that is the objective of the first year clinical posting. In second year clinical posting, is like we need to take an assessment of the client, of the patient. This is the objective of the second-year postings, in which there are some duration. It can be 200 hours or more than that. A student has to be in the clinics. It is after the University Grants Programme, UGC, with the UGC, I think. And the third year, we have to plan, like the goals has to be splitted into two, like short-term and long-term. A third-year student has to know what is a short-term goal and the long-term goal for the patient needed. And the fourth year is like every comprehensive thing of everything, like we need to create rapport, we have to do an assessment, we have to fix their goals, and also, we need to intervene with our patients. So, this will be the four years clinical exposure of a UG student, and the next six months, which is a compulsory internship programme, in which, from morning to evening, he should be, or he or she should be – will be in the postings in different specialisations for geriatrics, paediatrics, oncology, and so many things. Yeah, and this we’ll be doing, and the last six month internship will be – which is very essential, because we’ll be focusing and we’ll be seeing many patients, so that is the right thing for the internship, and comparatively, internship period is far – duration is very big.

I: Yes. Yes, it is, yes. Can you tell me about the different clinical areas that you’ve experienced as part of your postings?

R: Yes, ma’am. First and foremost, I will start with paediatrics. Generally, we used – I used to see kids from eight months, where they’re diagnosed with the developmental delays. So, what we had – some programmes we have in Ramachandra, early intervention programme. Okay, in which we’ll give stimulation, we’ll advise parents about these bad positionings, and so on and so on, the reflex inhibiting and reflex facilitating patterns as well. We’ll be explaining about NICU kids, the post-op NICU kids. Next, generally, in paediatrics, we are – it ranges from nearly 12 years of age, right, paediatrics. So, we used to see cases of autism, cerebral palsy, spina bifida, Down’s syndrome, many clinical syndromes like Williams syndromes, Asperger’s syndromes, many kind of syndrome, so and so conditions, and also we’ll be used to see both mental disabilities as well as physical disabilities, like hemiplegia, hemiparesis, generally hemiparesis, which later on develops into hemiplegia. We used to see this kind of – that is mainly infantile hemi we used to see, learning disabilities, PDD, pervasive development disorders, and so and so conditions in paediatrics. Next, I’ll go with psychiatry. Psychiatry, which – basically, we like psychiatry, ma’am, because connecting group therapy is very interesting, treating opposite minds, you know? It’ll be very nice, mixing them into packs like schizophrenia. We do have something like a mixed group and a non-mixed group. So the non-mixed one, for an example, alcoholism, alcohol dependence syndrome, where we’ll make them play like carrom boards, share some thoughts, and we have some alcohol anonymous groups, where we make the patients to come up, like, what they have done in that thing. And group therapy is very nice things in psychiatry, and placing them in occasional thing is very interesting, you know? And treating their minds and everything and making them to rehabilitate, and making them into community, reintegration is very nice in psychiatry, and also, prognosis can be much comparatively higher in psychiatry, I think, so, especially some cases, there are less prognosis, like schizophrenia. Yes, and in also schizophrenia, we have a lot of types, paranoid, schizoid, borderline personality, perhaps psychotic, obsessive compulsive personality disorders. So, these people have some – some are really comparatively low prognosis, but then we’ll make them – at least we’ll make – try to make them maximum independent in their ADLs. Next is geriatrics, dementia, Alzheimer’s, and many age-old problems, because patients, they have like – they’ll be long-term, but bedridden, they’ll have bedsores. So, treating like bedsores, we’ll make them engage in activities like group meal preparations, some kind of recreational activities can be done for geriatric patients, because there is much thing about – the psychological aspect of the geriatric patient is very thin there, because they are separated. So, we people generally used to go to their homes, treat them, make them participate in or engage them in activities, and group preparation, meal preparation, picnics, drama, music therapy, it’ll be very nice with the geriatric patients. And also, the thing is that when – after our therapy, which we’re going to give like musical therapy and all, they’ll – after the session, they’ll come and, “I’m so happy for the session, I feel so thing.” So, it’ll be like, you know, it’ll be goosebumps, even I’m getting right now, and the next is neurology, OT and neurology. Basically, I like neurology, especially, so neuro, and why I like it means because nerves, it is part of everything. We don’t – in the – we don’t have nerves – we have nerves in every part of our body, so, basically, I like neurorehabilitation very much. So, I basically – I personally saw many cases in neurology, ma’am, like brachial plexus injury, Guillain-Barré syndrome. A very important thing, which I need to share with you is, like, I had a session of a therapy, work with Guillain-Barré syndrome, I won’t mention his name. He is 25-years-old and he is a medical profession. Yeah, he is almost going to do his intern, and suddenly, with some viral intoxication, he acquired this Guillain-Barré syndrome. Well, I had an opportunity, because of my faculties, and they asked – because I have an interest in Guillain-Barré because – and they have sent me, along with another Occupational Therapist, to have a primary diagnos – a primary assessment. So, when I went there, I started, like, I started going more and more on Guillain-Barré syndrome, and after going through many books, I want mainly to do, like – I need to do something to him, because he’s like – he has wrist drop, foot drop, he’s completely bedridden, because it is polyneuropathic conditions. Guillain-Barré syndrome is a typical polyneuropathic condition, where the prognosis is very good, but it takes time. His hand extension has been lost, everything has been lost, so what we mainly start giving is, like, bed positionings. To avoid postural hypotension, we have some thing called tilting board. In the bed itself, you have some having some changes of the positions, so that when we make them to stand, he’ll not get fainted off because sudden pooling of blood from coming to the brain, it’ll cause fainting – and fainting. So, we have these positionings and slowly, we started giving this man find more activities to develop his finger dexterity and also, we gave him cock-up splint for the wrist drop. Slowly, he recovered and then he – he’s a left hand dominant because more on is left hand dominant, he started gaining some power in the left hand than comparatively to the right, and then we gave him adaptive devices. There’s a universal [?] and palmar pocket which is used for the eating. First, his mum was feeding him, and then, when we gave this adaptive device, he started eating. What that meant, you know, when he started eating, oh my God, at least we did something to help. This adaptive device make him to – made him independent in eating, so that was a very good moment I had working with patients like Guillain-Barré syndrome, so that was my, you know, hmmm, something, I couldn’t express it. So, neurorehabilitation, I loved it. I love so much.

I: Yes. Can you describe, with that gentleman you were talking about, how – what your thought process was. So how did you get from looking at books to having him using the adapted…

R: Oh, so…

I: …feeding equipment?

R: Yes, yes, yes. I generally personally asked them, “What do you want to do? In which way you want to be independent?” He said me, like, “I want to eat myself.” First, he said, like, he don’t want to bath, he didn’t say anything, “I want to eat by myself,” he said. So, when me and another Occupational Therapist was intervening him, we were discussing, like, what can we give him, what, you know, what can we suggest for him? So, suddenly we – he started gaining this wrist flexion, so with the help of wrist flexion, we can make him to – he has elbow flexion and elbow extension, he has the power. So, okay, we can train him with this palmer pocket aid, so what – so that made me – made us to give him this palmer pocket aid, based on his interests, ‘cause it should be like customised. It should be cosmetic purpose also, because having a big thing, big stuff in his hand, it does not like nice, so what we made, we made the leather thing of it. So, cosmetic purpose, everything we have saw and we gave him, and then that was a nice experience. Yeah.

I: Yes, and I can see that that made you…

R: Yeah.

I: …very happy.

R: Yeah.

I: That’s good. So, can you tell me what your view is of the purpose of doing clinical postings in your course?

R: Generally, having a clinical posting is very essential. For – in health profession, because this is not something like art and science programme. This is a professional programme, so a student has to have both academics, as well as the clinical exposure. When these things going to come – when these things are integrated with this curriculum, so that when he come up in his graduation, he’ll be a good Occupational Therapist professionally. Yeah, wherever he goes, the thing, like, which he gained from this institution will be recognised. So, if I’m going to work in some other institution, they’ll ask me like, “Oh, you’re performing some good, he is okay with this profession thing.” Well, they cannot come and ask me, “Which college did you study?” So, I’ll explain like this to him, like, we – I had a clinical exposure, morning half and evening half. Morning half is like clinical exposure and afternoon academics, so this both, when mixed to – mixed in my academics, which made me like this, which made me come up like this. So, clinical posting is very necessary, and also, clinical posting does mean, like, not sitting – and not going and sitting in consultation room for hours and like that it’s not possible. We need to touch patients, feel their thing, and we need to do, ma’am, ‘cause we have some ethics and etiquettes, professional conduct, autonomy, maleficience, so we have to, yeah.

I: Yes, yes. Can you tell me a little bit more about how you link the academics to the postings?

R: Okay, ma’am. I had a morning, I used to go to clinics. I’m seeing an autism spectrum disorder patient, and he is auditory hyperactive or visual hyperactive, hypersensitivity, okay? And in that session, I’ll – at least I’ll make him come and sit and everything I’ll do. I’ll come to the afternoon session after the academics, I’ll talk with my faculty, like, “I had a case, like, this, what I’m supposed to do? I did like this, whether this is correct or not.” So, I’ll interrogate with him, like, “Sir, I have seen this autism spectrum disease, this is what I gave, and this is what I experienced. Do I need to put any other input or I should not use these things?” I’ll ask them, if it is going to correct – if it is going to be correct, they’ll allow me to do. If not, they’ll suggest me these things, “Okay, go and put him into some dark room, so that he’ll get sensitised.” So, if it is going to be very auditory hyper, put him in the silent, he’ll calm down. So that I’ll interrogate like this with him. Yeah, also, for CP patients, CP patient, especially they are many times, ma’am, their muscle tone, muscle – like, I’ll give some activities. For an example, if I don’t know how to test muscle tone, I’ll click a picture of this – of the patient, with the consent of his mother, and then I’ll show this picture to my faculty, “So, Sir, I am feeling some difficulty with measuring this muscle tone, but I know the Modified Ashworth scale muscle tone, gradings I know, but I want to know how to measure it.” So, they’ll explain to me, so this is a way we used to interrelate with the academics and clinics.

I: Okay, great. Can you tell me about what you record on your postings?

R: What you…?

I: What do you – what records do you keep?

R: Okay, ma’am. Clinical postings in general, we have some log note in which serial number, name of the patient, date of today’s thing and the diagnosis, what is he diagnosed? And the age of the patient, gender, and their treatment, which we’re going to give to – the therapy given, and there is a separate column, we have therapy given. The next thing is, depends on faculty sign, so if I’m seeing this patient on this date, with this – in this patient, with this condition diagnosed, he is in this age, of gender, I gave him this therapy, the therapy which has – which I have given, he’ll cross it with everything, okay, this is correct, he’ll put sign.

I: Can you give me an example of what you would put in the therapy given column?

R: For an example, there is going – patient with attention deficit hyperactivity disorder, example, ma’am. The therapy which I given is attention-based activity, floor-based activities, so to improve sitting intolerance, and a cognitive-based activity is a colour bright activities, to make him eye con – to improve his eye contact and to improve his sitting tolerance. And this is how the thing – and the obstacle crossing activity for this – for an example, with hemiparesis patient, I gave this obstacle crossing activities to strengthen their proximities, then clay activity to improve the fine motor skills, to help prehension, tip-to-tip, palm-to-palm, and improve tip-to-tip prehension, palm-to-palm grasp. By throwing this ball, like throwing a ball in the basket, this improves eye coordination, bilateral co-ordination, spherical grasp, his power, stone(?), everything I will.

I: So you record that…

R: Yeah, ma’am.

I: …that amount of detail? Okay, great stuff, and how do you use that, then?

R: How do I use that?

I: Yeah, what do you do with your log?

R: That log is like – it – for all four years, ma’am, and there is like clinical posting four. Clinical posting one, clinical posting two, clinical posting three, clinical posting four, for the four years. In each year, there is 100 marks for the clinical postings, for the university purpose. So, we need to get more than 88, I think, ma’am, to pass in that. That is based on a performance, which we do, and number of cases we saw, number of output we gave, number of inputs, which we given other – what are the creative activities, which we did for the patients? All these things will be recorded by the faculties, and they’ll give some marks for the clinical posting, which will be calculated in the university total marks. So, per year, I should get these marks. So, the CGP year, of my exam, of this current year, is this one, is the all – addition of all these things here got.

I: Okay, so, how do you think completing that log contributes to your learning?

R: Because I’m learning about this case, I’m seeing a case visually. Everything which has to be learned, it has not been the case. It will be different in learning; it will be different in practical session. So, how I am relating with this, so…

I: Okay, great. Could you tell me about any particular events…

R: Okay.

I: …from your clinical postings…

R: Okay.

I: …that really – that you really remember?

R: Yes. Many, and there are many things. I’ll – one thing is that Guillain-Barré syndrome, which I told you, and that thing. Next, second is the psychiatric group therapy. Third one is, like, in paediatrics also, we’ll conduct group therapy, like, there are these attention deficit disorders, you know. They’re very hyperactive, what we make is, like, we’ll, like, give many colours, many sensitive parts, and there’s auditory inputs. When we start giving them, they’ll be like, you know, they’ll have – the hyperactivity when they enters into it, and they come out of there and as they enters, they’ll be like, “Oh my God.” They’ll like – they’ll feel tired. Oh my God, this hyperactivity turns like this, or we’ll be like, you know, “Oh, okay, yeah,” something which they get is working out in this. And then next is like one thing about this, do you know \*\*\*\* grasp? The – like, we have this passive act to sufficiency in the muscles, right? That grasp is like – for patients with hemiplegia, they cannot take this pen like this (demonstrates). For them, we’ll help them to sustain on this grasp, like we’ll make them do like this, wrist flexion, what the phalanges would like, it’ll flex of these insufficiency, see like? Flexion, and then, when I extend it, the pen can come and lock. He don’t want to use his phalanges. Okay, see, like, if I’m going to flex my wrist, it’ll go and park this pen, and then, when I wrist flexion, wrist extension, it’ll hold. So, compensate with strategies, so, which I learned from the clinical exposure. So, this, yeah, and the paediatrics I continue yeah, until three sessions I took.

I: Can you talk me through how, for example, you were talking about the children with ADHD…

R: Yeah.

I: …and you talked about the – doing the tunnels…

R: Yeah.

I: …can you talk me through how you decided to use the tunnels?

R: Tunnels, it’ll be generally dark in thing, so when they’re getting to bed, like, this’ll be a big tunnel. So, when he was standing in this light, it was an ambient, it was colourful thing. When he enters into it, what he’ll do is that generally his hyperactiveness decreases because of the darkness, and, like, he’ll get fear of it. So, he’ll come slowly through the tunnel, so when he comes out, okay, yeah, again he’ll get. So, some other activity, which will be switching over. So, these are not random activities, which we give, ma’am, this is not something like structured. This is all semi-structured activities. With reference to faculties, we’ll give on this one.

I: Yes. Are there any situations that you remember that were particularly difficult?

R: Yes, ma’am. Generally, severe autism, so, yeah. I’m giving therapy for severe autism, it will be very difficult, because if I start forcing them to do some other activity, they’ll just beat me up. So, taking patients with autism, severe autism is especially difficult, and also, post-stroke patients, stroke, neurology patients, hemiplegia, stroke, another traumatic brain injured patient, and when intervening with them in the post ICU sessions and all, they’ll be very, you know, angry, because they have many confusion going in and out in their brain. So, they’ll not – yeah, and they’ll not have a good rapport with the Therapist. They’ll throw anger and throw temper tantrums will be there ‘cause yeah, generally, we have – we need to accept them because many things will be going with them, because they cannot open their brain. They have then, the cerebral [inaudible – 23:06] everything they’ll be having, but then, when we ask them to, for an example, “Mr X, can you just lift your hand? Can you just take this peg off the ring?” He’ll just take them and throw it off. So, treating neurology post-op patients, it’s also very difficult. So, training in this clinical posting can make them practise good in their positions.

I: Yeah. How do you feel when it’s difficult like you’ve described?

R: How do I feel? It is very difficult, because I cannot – one thing is right, their parents are giving their child to us to make them – control the other – they’re going to have a faculty make them sitting in – to make them sitting with tolerance. That way it is their frustration on, and when I gave them – when I – just, generally, the session would be 45, or a 30-minute session. When he was coming for the first – when they’re entering to therapy session, they’ll be hyperactive, but when they go out, at least I should make them some improvement. At least I should some – give some improvement to their parents, like, today’s session, he came and was running here and around there, and then I gave him this colour activity and then they sat, and then they were co-operating. This is how a parent will – their attitude will be like this, “Okay, after this session that person achieve like this. But in practical thing, on 100% thing, 80% can be we can satisfy the parents, but rest 20% it will be difficult. When they’re coming in, they’re hyperactive, and they also, after the session, they’ll be hyperactive, so the patient – parents will feel like they’ll have some psychological things, “Oh, why I’m sending to, they are doing nothing?” But the thing is that we will be doing many things.

I: Yes, and how do you feel then, if the parents are not happy?

R: One thing is like I don’t have that experience. If they – if, generally, if patient have and parents have that experience, they’ll not comes directly to me and they’ll not say, because I’m going to see their – and see their kids for a long time, so they’ll not come and say directly to me. What he or she will do is go and say something to the faculties, like, “This is how he was and after the session also, he was like this, so what can be the – whether you can change the Therapist or the student Clinician,” they’ll ask, and then with – in a polished manner, and faculty will come and like, “\*\*\*\*\* change this activity to, like, this. So, change this like” – so, automatically, I’ll get like something has been happen and some parents don’t say. I have to – We need to get the positives, also the negatives. Only the negatives we can get, so that we can change it to positive, so we cannot always expect only positive things. Negatives should also be expected, and also, we need to change this. Something like a reinforcement thing on that.

I: Yes, yes. Okay, so is there anything else that you would like to tell me about your postings? Anything else that you want to tell me about?

R: Of my postings, ma’am?

I: Hmmm hmm.

R: Basically, my posting, I love clinical postings, ma’am. The academies, I love clinical posting because sitting in a class, listening to a long, say, a lecture, oh, err, than working with the kids, no, this is bored. So, I generally like clinical. If my clinical postings has been extended to an extra hour, it’ll be nice for me because I can see more patients, I can see more conditions, because, like, if I’m going to working abroad or some other countries, they’ll generally look off this clinical posting notes. The purpose of this clinical posting note is like, when you’re going to some other country, they’ll ask you, “How many condition do you have, Sir? What is their evidence?” They’ll ask evidence, so this is our evidence-based practice. I have this thing, I can show you. So, it’ll be helpful for me, if I’m especially going to work in some other countries like this.

I: Yes.

R: That shows my potential also. Okay, has saw some new – these many conditions, this many hours, he has this many clinical rotations, so, yes, we can have trust in him, so that – I think, yeah.

I: Okay.

R: Wonders can happen.

I: Yeah, yeah. So, how has it been for you talking to me about your postings and your experiences?

R: Generally, I haven’t talked any about my clinical posting, except my parents, to any other. So it is very happy for me to share, because when I share with you things, I remember – I’m getting remember of many things, especially this Guillain-Barré syndrome, when I get started and to make me – my endorphin and enkephalins started the happiest I’m secreting. So, generally it makes me smile. It’s nice thing, because…

I: Good.

R: …when I share many things with you, hope you will also.

I: Yes.

R: Yeah.

I: Yes, that’s great, thank you. Okay, so I think we’re all done.

R: Yeah. Oh.

I: Okay, so I’ll just turn this off.

**[End of File – 28:12]**