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I: Okay. So, just to be clear that you have the participant information...

R: Yes, ma’am.

I: ...and you’re happy to continue with this interview today, yeah?

R: Yes, ma’am.

I: Okay.

R: It’s okay.

I: And do you want to introduce yourself?

R: Yes, ma’am. Myself is \*\*\*\*\*. I’m studying the OT third year in Ramachandra University, so, yeah.

I: Okay, that’s great. Just to start with, can you tell me about the clinical postings on your course?

R: During first year, I don’t understand what is OT, what we do in this clinic. Because I only observed the clients and during my first year, then I went into my second year. I was done by assessments, treatment plans, and how to interventing in two-year community setup. First year I will – and during second year, my first client was – the name was \*\*\*\*\*. He was a hemiplegic client, infant and hemiplegic. That time, I will assess the patient and set a goal. During the approaches, ma’am, we have the approaches to – we have the approaches for the intervention, ma’am. Like Rood’s approach, PNF, [inaudible – 01:30], like this approach. We have separate techniques to intervene for the specific problems. For example, we take a spasticity tone, we put the Rood’s approach, some of the technique, ma’am. Like the passive stretching to reduce the spasticity for the – for later. Then we – we have two set ups ma’am, paediatric and psychiatric I can take during my second year. Psychiatric – we have many of the clients, ma’am, like conditions like schizophrenia, bipolar, substance abuse, like that. My practical exam, during a practical, university practical exam, I was very confused because I have no idea about that which client and which condition did they fit. Because most of the symptoms are similar to same conditions, like bipolar, personality disorder, borderline personality, and paranoid schizophrenia. Then I was confused at all, ma’am. Then I will come, come, come and find and I will take the symptoms of each conditions, ma’am, and according to ICD 10 we have the symptoms, we diagnose that I have the delusion part of schizophrenia, ma’am, and I decided it was paranoid schizophrenia. It was a very difficult situation to understand my – because that is university practical, ma’am.

I: Uh-huh.

R: I am fear to fail. Sorry, ma’am. I am not talking English fluently.

I: No, you’re doing very well. That’s fine.

R: Yeah, then third, coming third year, ma’am. This year, third year, I have seen lot of condition orthopaedic, neurology, and paediatric, ma’am. In orthopaedics, we have the fractures, the totally hip replacements and hmmm, rheumatoid arthritis, osteoarthritis, in like the conditions. I saw one rheumatoid condition, rheumatoid arthritis condition. First, we observe the patient through COPM, Canadian Occupational Performance Measure mark, that scale, ma’am. Then we have general informations about the client. Demographic data, and on observation, the client was – how will – how the client came to our department, like that. Then, on examination, the client was – we assessed the patient to attitude of feelings and attitude of the limbs: muscle tone, muscle strength, like that, and we set a – we provide a – we set a – pardon, ma’am. Hmmm, we know the problem list of the patient and set them short-term and long-term goals, and the intervent for them. Okay? The intervention should be the rehabilitative frame of reference, it is enough, the reference, to use all the conditions in our profession, ma’am. Because the – that rehabilitation condition frame of reference are the composite techniques, joint protection techniques, energy conservation techniques. We give – we should give the patient to a joint protection technique how will you use the joint for the patient? Some of the examples are – hmmm, we teach the proper biomechanics of the joint to the patient. It will be useful for the use of the joint and to prevent the deformity or the contractures of the joint. We taught the proper mechanics of the joint, ma’am. And then, energy conservation technique we provide a – don’t use if – don’t use spine joint during lifting the object. Instead of using of the knee and the hip joint for the – during lifting the object. These are the intention for the rheumatoid arthritic, ma’am. And neurology, like paediatric infantile, I told that the infantile hemiparesis. Like that, I saw one TBI client, ma’am, in our OPD. Name is \*\*\*\*\*. He had a fall in [inaudible], ma’am. He have the problem in ADL, ma’am. Activity of daily livings like bathing, bathing, toileting, that’s all, and he have the problem in memory, ma’am. He have the problem in the emotions. One day, my clinical posting day, Down syndrome one boy, \*\*\*\*\*, 20-years-old, and a TBI Patient, I give – I gave that group therapy for him, ma’am. We play the Kit-Kit game for the [inaudible – 06:30] activity. First thing they – and the TBI patient talks of their emotions with Down syndrome. That was very happy moment for me, ma’am, because I saw, yeah, improvement in that client. Okay and then, that’s all, ma’am.

I: Okay. What do you think is the purpose of the clinical postings in the course?

R: Hmmm, first we know the problems, ma’am, during what are the happening in our community setup. What are the patients – first, we identify the patients and identify the problems. According to the problems, we setup the goals and the purpose of the clinical posting is how to – then, how do the patients, our client, enter into the community setup? How will the occupational therapy manage them? That’s – I think that is the purpose of the clinical posting, ma’am.

I: Okay. How do you link your academics, your academic work with...

R: Clinical postings?

I: ...your postings, yeah?

R: Ma’am, firstly, we understand the conditions like – first, we understand the conditions in pathology, clinical symptoms and the investigations. What are the drugs the patients are used? The drug side effects, and other side effects, and the usage of the drugs. That all Occupational Therapist knows only, we intervene for them because some of the anti-arthritic drugs can give fatigue easily, ma’am. Then the therapy was given by the Therapist is totally wasted because the patient is fatigued. That’s all we know. It is important to know about the clinical practices, ma’am.

I: Okay. What records do you keep of your postings?

R: Ma’am, we have the clinical posting note, ma’am. We saw client today, then we record in my note and what are they give, and in that note, name and sex, age, what are the conditions of the patient, and what treatment can be given by the Therapist? I’ll fill that and sign from our faculties, ma’am.

I: Could you give me an example of what you would put in that final column about the intervention?

R: Okay, some of the – ah. For example, we take the TBI Patient and because I saw most of the time that patient only. His name is \*\*\*\*\*, 43-years-old. He was diagnosed by TBI patient, as a traumatic brain injury. We give the sensory re-educational treatment, ma’am. In treatment, we give cognitive retraining, sensory re-education, then our rehabilitative frame of reference. According to this reference, we give compensatory approaches to intervene for them. That and all, we write in the logbook, ma’am.

I: Okay. So sometimes you write quite a lot in the logbook...

R: Yes, ma’am.

I: ...and, yes, okay.

R: In that – during this approach, what are the improvement component. For example, we take the PNF technique, one spasticity stretching is taken from the PNF. It’s to improve bilateral co-ordination, stretchings, to reduce spasticity, to normalise the muscle tone. Like that, we work in the clinical posting of that.

I: Okay and how do you use that afterwards? After you’ve written it, how do you use it?

R: Sorry, ma’am?

I: Do you look back at it? Do you – what do you do with the log?

R: Ma’am, it is one of the record of our internal marks, ma’am. Because what are all the patients can I – can saw during my clinical posting. The external examination – examiner can ask my – can see my clinical posting logbook and ask the questions to me, ma’am. What – for example, sensory integration approach. How will you use the sensory integration approaches for this type of patient, that type of patient? For example, paediatric condition, how will you use? And the orthopaedic conditions, or the neurology condition, how will you use? Because the conditions was different, the approaches are different, ma’am, used.

I: So you will have to justify...

R: Yes, ma’am.

I: ...what you’ve written.

R: We justify with how will you use the approaches during the patient?

I: Okay, great.

R: Ma’am, can you understand my English?

I: Yes, yes. It’s great, it’s fine.

R: It’s hard, yeah.

I: It’s better than my Tamil.

R: Huh?

I: It’s better than my Tamil.

R: Right.

I: Can you tell me about any particular situations that you really remember about, from your postings?

R: Hmmm [pause]. Hmmm, first year, first memorable thing is that a TBI patient got a result in my therapy, ma’am. Second on – during second year, I was done one assessment during second year. It was a great, wonderful moment, because I had nothing to know, ma’am. Anything, I don’t know. That’s empty mind I will learn and assess the patient for the first time, and I will – after that only I learn many things to know about occupational therapy and the interventions, approaches. Because, a lot of insults (?) to me for the [pause] do properly assessment, ma’am, so that I will learn quickly, as much possible.

I: Okay. So, anything that you can – that you really remember from your postings, that was difficult?

R: Hmmm [pause].

I: Maybe a time when something didn’t go right.

R: Hmmm. Sometimes the – in psychiatric setup, the patient will not co-operate with us, ma’am, because they have a mood disorder, they have their mood swings. So that they are not under – and they are not – they are not understand our situation, and because he have psychosis and neurosis. Neurosis condition, easily we can mingle with them and we give therapy. But psychosis condition, it’s very difficult to mingle with them, because they have lonely or isolated them self. So, one time, once upon a time, they – one of the patient ignore my therapy to them, that time I will – the most difficult time. Because I am not interested in psychiatric setup, ma’am, because that only. Not – no co-operative. Co-operation is not there from the different setups.

I: Okay. So what did you do? How did you manage that?

R: Ma’am, how did it? Ma’am, sometimes the other peoples will play with us. They will – they can see that patient. We force it like, “Come please, come please.” Told like that, they will definitely, once a day, will come to play with us and join with us and that time only, ma’am. Yeah.

I: Can you tell me a little bit more about why...?

R: Ma’am?

I: Can you tell me a little bit more about why...

R: Why the pa…?

I: ...you don’t really like psychiatry?

R: Yes, ma’am, because it was very confused the setup, ma’am, because we manage – my batchmates are managed psychiatric setup, but I won’t, because I am introvert character, ma’am. Basically, I am not sharing anything to anyone. But the patient also said – I am not a jolly character, ma’am. I am a – so, I’m not interested to please the characters, please.

I: Okay.

R: Okay, that’s why I am not interested. But the neuro setup, I can see the improvement in my daily days, ma’am, daily therapy sessions because we work with a lot of fun with thing – with things.

I: Yes, but sometimes the patients in neurology can also be quite un-co-operative.

R: Ma’am, but we do physically the therapy, ma’am. But in psychiatric setup, they ignore many times, but any time they will come, but not all. But in neurology condition, we work with the daily, ma’am. We work with daily, we share some thoughts to him. They also share some thoughts, but we physically doing, and the improvement we’ll see.

I: Okay, that’s good. Is there anything else that you want to tell me about your postings?

R: No, it’s a very [pause] – hmmm.

I: There doesn’t have to be.

R: No, I will think, ma’am. It’s very useful to us, ma’am, because we see many clients, ma’am. Because many colleges are – I don’t have the client who saw the patients during their student period. But we can – only Ramachandra students, we can see all the type of patient during the, hmmm, clinical postings, because in our faculties teach them, teach me, teach us, and guide for – guide for us. We should take assessment properly because of them only, ma’am. Then we give therapies – we have the different ideas, ma’am. We have the different ideas for the different patients because we share the thoughts during our class hours. We share our thoughts on what we do today, our clinical posting hours. That’s a lot we manage, ma’am. We easily manage the patients and we easily know about the community setup. We even know about the parents’ or caregiver thoughts.

I: Okay, great. How’s it been for you, talking to...?

R: Hmmm?

I: How has it been for you, talking to me about your postings?

R: Hmmm. No, ma’am. I will not talk about anyone.

I: So, you’ve been telling me about your experiences on your postings.

R: Yes, ma’am.

I: How was that for you? How did that feel?

R: Ma’am, it is very interesting, ma’am, because you know about our postings and our treatment methods and our intervention plan and our assessment. We are – you are also know about Indians are using this type of techniques, this type of approach is used, this type of assessment can be done by them. But I don’t know your assessment forms and your – so, that I don’t know.

I: Okay.

R: But I think it’s useful for you.

I: Which is – it’s very useful for me. I was just wondering whether it was useful for you, to talk about things you’d experienced.

R: Yes, ma’am. Very useful to me, ma’am, because I will...

I: You think so?

R: We will share about our thoughts and feelings, ma’am. So that this is the first time I will speak to one-on-one conversation for foreigner, ma’am. This is the first experience for me.

I: Okay. Okay and...

R: Next time I will, I will speak without fear because this time we speak. Next time I will definitely speak well because I learn.

I: Yes, okay. Thank you. Right, I shall turn it off.

**[End of File – 19:51]**