3



**ALL AUSTRALIAN SERVICE PROVIDER Since 2004**

Service@eScribe.com.au  
eScribe.com.au

**Transcription & Captioning  
ABN:** 21 164 807 336

|  |  |
| --- | --- |
| Monash University - Felice Borghmans | |
| **Transcript:** | Research Interview SENSITIVE: Personal |

|  |  |  |  |
| --- | --- | --- | --- |
| File Details | | | |
| Job Name: | Felice's research | | |
| Billing Ref: | [Not Provided] | | |
| File: | Mins: | File ID: | File Name: |
| 1 of 1 | 49 | 24008 | participant 3 site 2.mp3 |
| Total Minutes: | 49 recorded minutes | | |
| Date of Recording: | 11 December 2019 | | |

|  |  |
| --- | --- |
| Speaker Index | |
| Identifier Name Role | |
| **Bold Content:** | Felice Borghmans, student Interviewer |
| Plain Content: | “Jane” Interviewee |

|  |
| --- |
| Start of Transcript |

**File 1 of 1**

## I’m really keen to hear your thoughts.

### So what’s your background professionally?

## My background is nursing. So weirdly I came into it quite late because prior to that it was nightclubs and working behind bars and actually making people unwell.

### You’ve split the spectrum.

## I’ve been trying to pay for it ever since. So I’m very familiar with the cohort - being a HARP manager. Yeah, I’m very familiar with the cohort, but, yeah, and I guess most of my - like, my early career was in critical care and I did a post grad in that and then I just decided I really wanted to stop people coming into hospital and that’s when I went into sort of working in community, started in [Named health service] and then I was actually here for 14 years. I was across [Named health service] and post-acute care and resi and Reach and Staff health clinic. That was my portfolio years ago and then left and went to [Other health service] and then came back to [Other named health service] yeah, to pick up management there.

### That’s an interesting journey.

## A little bit of a journey yeah. So anyway, if you’re - before you share anything, have a read. So the things that I will be using your data for, it will be utterly de-identified. The only people I share my data - my raw data with are my supervisors, and I’ve got three supervisors. They’re all academics at Monash uni and one is a professor at [health service] as well. And so there may be some direct quotes, but I’ll always look at making sure that it can’t be directly connected to the individual.

### Yeah, that’s fine.

## Yeah, and I do send the transcripts to you for -

### Yeah.

## Yeah, and sometimes I ask if you would like to embellish or if there’s anything else you’d like to say. Alright?

### Yeah.

## So if you agree to any of that, or don’t agree, just tick what you’re happy with and what you’re not happy with. I wish I could print them out in duplicate, but I’m only doing, like, a few at each site. This is multi-site, three health services involved.

### How many have you done so far?

## You are my third formal one, but I’ve done lots of little practice ones. I pick - I get some of my team members and say, “Can I ask you some questions just to practice what it feels like asking questions?”. Yeah, but I’ve only just really started the research. The ethics actually took from February to - I’m still going through it with one health service. Yeah, I think people worry when you say you’re asking clinicians about what they think about practising in their organisation, but I’m not asking you to comment on your organisation at all. It’s not about that. Yeah. So one of those is for you. So I’ll hold on to this one if that’s alright.

### Actually, I probably don’t need to do this part.

## Yeah. I’ve got my list of questions. So the way I do this, as I really - you can take the conversation wherever you like. I’ve got some sort of ballpark areas I like to talk about, I’d like you to talk about, but, yeah.

So I guess the first one is really if you could please describe your role, what you do in the hospital and where your role takes you?

### So my current role is as the senior clinician, physiotherapist, at a grade 3, in our acute and complex care stream here at [Health service]. So physiotherapy at [Health service] is divided into streams and, therefore, patients - they’re patient units or the medical fall under particular streams. So to add context, there’s, you know, women’s and men’s health, musculoskeletal, neuro, crit care -surgical, paediatric, gerontology and then my [0:06:21] is acute and complex care. So we span across multi-sites at [Health service], the three acute hospitals, and so I’m the kind of grade 3 team leader for the team here at [Major site].

## It sounds like a big role.

### It is. So my team has two allied health assistants, six grade 1s, five grade 2s and myself, and I report to one grade 4 who isn’t based here, and then a manager who is based here but doesn’t have direct kind of - like, I don’t report to him for my supervision. So we are a big team. The kinds of patients that we see in our team here are general medicine, respiratory, renal, haematology, oncology, the Emergency Department.

## Very mixed, isn’t it, yeah.

### We have the private component, so {provide hospital name]. We service the medical bed cards there. Goodness, what else do we have in our stream?

## And so with those - in those sort of, I suppose, disease or cohorts, those people wouldn’t just be presenting as a one thing, they have [0:07:34].

### No, that’s right. So that’s, like, my team’s role. So as the grade 3 senior clinician, I oversee my team in that area, but my clinical service provision is primarily to our general medical cohort and then I just provide kind of like consultative service to the senior staff as required for their patients. So -

## And you supervise them?

### So I supervise each of the grade 2s and the grade 2s supervise the grade 1s, yeah.

## A big role.

### Yeah, a lot to fit in. So my prime clinical area is general medicine and that’s where I’ve worked for the last six or so years and that’s where my interests lie for myself as a clinician, so, obviously, I do - I have plenty of patients who have multi-morbidities and who are in hospital with a variety of interrelation, like, interrelated problems, yeah.

## What do you like about it?

### I like that no day is the same. I don’t like the kind of clinical - when it’s that - like homogenous kind of, like, every patient has had surgery or every patient’s had a broken - but I like that gen med is different, I like that you generally get to make a really big difference in someone’s life with the kind of intervention that we’re doing as physios, I like that you get to have a bit of medical knowledge with it. I enjoy that. I’ve developed my - the medical knowledge which you, perhaps, don’t need in other clinical areas as much, and I just - yeah, it’s just a really interesting area that keeps things ticking over.

## And do you work in an interdisciplinary way or a - how do you work with other healthcare professionals in the hospital?

### I guess it’s probably a mix between multidiscipline and interdisciplinary if you go by the formal definition. So here at [health service] we in the physio service [0:09:44 by bed card] as I mentioned, so we are part of an allied health team that services the general medicine patients or the renal patients or what have you. So for myself I am part of the team that services the general medicine patients inclusive of, you know, OT, social work, speech, dietetics, podiatry as well as nursing, pharmacy and medical. We also have strong ward teams, so I’m the allied health lead on our ward governance team, so I sort of drive the kind of ward from that broad allied health perspective and a ward governance level.

## And does that create some consistencies in the team as well in how your structure works?

### Yeah, we try to. So we try to - for example, we have two kinds of home general medicine wards. The ward governance team for each of those wards work quite closely together and at a program level we try really hard to make sure that there’s consistency of practice and of routine across so that hopefully we can, you know, try and streamline things, yeah. So we have a really strong link to, like, the allied health professions but our other colleagues as well.

## Right, okay.

### Which is essential for these patients, yeah.

## Right. So tell me about that. Tell me why that’s essential because that’s really interesting.

### Yeah, which is probably another core reason why I inherently love general medicine, is that teamwork. I enjoy that, you know, we do need the health care team, so with the multi-morbidity patients and the complexity that exists in general medicine, you do need each member of the team to bring that next piece of the puzzle to kind of put it all together, and so I think general medicine is a really nice place where we have a holistic look on things and perhaps not ideally if you look at the care that is delivered in other units. I think it doesn’t always reach that far and there’s less consideration of the team as a whole. So I think -

## Those other units, and why would that be?

### I think if you think of a unit like, for example, a surgical unit, it’s not always the case, but stereotypically I think the patient comes in and they need an operation. The surgical provide the operation and then they’re kind of, like, “We’re done. We’ve done our job”, and there’s less consideration of what else exists about that person and how they might need to get better to go home or what else is going on for them. They tend to be very, like, single system focused.

## Yeah, it’s a gall bladder or it’s an arm or -

### Yeah, and it’s out now, so I’ve done my job, and I think, you know, when I had been a junior physio I’d worked in orthopaedics for a bit and I remember the surgeon, you’d say, “But they can’t go home. They can’t walk”, and the surgeon would say, “Well, I’ve fixed their hip fracture, so I’m done”, like, “I don’t care what happens from here”. It’s that real single - whereas I think general medicine is so good at looking outside the bigger picture and so too a lot of those similar - bed-cards within my stream, so you’re thinking of those more traditional medical bed cards like haematology or renal or respiratory. I think everyone -

## Non-communicable stuff?

### Yeah. They’re really good at looking at the big picture of the patient as a whole and what else do they need, how is their cognition or their nutrition or, you know, are they actually able to speak and swallow and putting all those things together to provide the best care for the patient rather than just their - what they need to do at that time.

## It’s so interesting, isn’t it, because, you know, you just do wonder why, if you’re practising in this field, you would think this way, and if you were practising in that field, you kind of don’t even kind of think about that.

### Yeah. I think it’s quite clear. I think if you, look - you know, if you look at people who work in, perhaps, intensive care, it’s all about numbers. It’s just about the numbers of the bloods, of their respiratory system, of the whatever it is. It’s all about the numbers and the rest of it is just not and, obviously, when someone is in intensive care they’ve got big medical issues, but I think in the medical [0:13:46 bed card] they’re very good at that broad picture and it’s not just about one system, but how they all actually interact and what that means for the person at the centre of it.

## Yeah, and is that empowering as a clinician, is that - you know, yeah.

### Yeah, I love it, because you want to feel part of the team, you want to know that you have your role to play, that you can help, you know, shape this person’s care, whereas I think satisfaction for staff that work in areas where - I mean, everyone wants to feel appreciated and acknowledged and, like, they have a role to play, and if you had a surgeon turn around and go, “Like, I don’t care what you do. Like, I’ve done my job”, that’s not a very -

## Do you feel a bit devalued?

### I think so, yeah.

## Your knowledge, do you?

### And I think, you know, there’s certainly times where in other units, not ours, you know, physios have been told, like, “I don’t really care if they can walk or not. Like, I’m sending them home today”, whereas in general medicine or our medical units it’s much more - if we say that they can’t go home and we need to think of another plan, that’s fine. Like, let’s figure it out. It’s not that, “Well, I’ve made my decision and that’s that”, that kind of patriarchal -

## You’re part of the decision making where you are.

### Yeah. So I think that is, like, a massive thing to bring that to a team.

## Yeah. And in your junior staff, do they feel empowered too? They would be exposed to different sort of conversations.

### Yeah. I think it’s a process because I think it’s also that whilst as a senior clinician or someone who, you know, has experience, it is empowering, and it is great. It’s also not easy to get there. You know, to turn around and talk to a reg or a consultant and say what you think or question them or adding your two cents isn’t easy, and so I think for junior staff it takes a lot of coaching and development for them to have the confidence to speak out in a team, to involve other team members. I think the funny thing is that whilst it’s great when you experience that and you’re confident with it, on the other end of the spectrum it’s a really daunting position to be in, and probably just easier if someone didn’t really take much notice of you. So we work hard on encouraging the junior staff.

## For advocacy.

### Yeah, to be part of the team.

## Given that you’re in such a challenging sort of environment, you’ve got this big role, you’re responsible for a lot of people’s practice apart from your own, a lot sits with that, what do you bring of yourself to this work? Like, how do you situate yourself in this to be able to practice it at such a sort of high level every day in such a complex environment? What’s that like for you?

### That’s an interesting question. I think - I think I have very strong self-reflective skills and so I think that as a leader I try to be fair, kind, you know, all those things to my team, and I think that when you do that it allows you to then practice your actual clinical job better because I think that if you - like, if I am having a day where I’m, like, managing my other, you know, supervisory or manager roles, you don’t want that to impact your patient care, and likewise you don’t want to feel - to be invested in a negative way in patient care that that impacts the other part of your role. So I guess it’s about self-care, not taking things home or where possible not taking them home and not letting them kind of bleed between the bits, and so I tend to keep things quite, you know, structured and streamlined such that they’re not crossing over, but I’m not sure if that’s - you know.

## It sounds like it’s an important part of this role.

### Yeah.

## It sounds like it’s really important to you.

### I think I take pride in knowing that clinically the service I deliver is of a high standard and I’m doing the best in the patients that I see, but that I’m also - I take pride in knowing or promoting that my team provide that same high level of service provision.

## So how - can you please talk about how - because physiotherapy, there’s a whole amazing research that happens in physiotherapy, there are a lot of grounding in evidence-based practice, but then trying to marry that with the variety that you see in Gen Med - they’re never going to completely fit the stereotypical standardised patient.

### Yeah.

## What’s that like for you? How - did you have to do a lot of adjustment yourself in that thinking or what was that like for you?

### It is. It certainly is a very difficult area to - because it is so broad and often evidence isn’t always in a multi-morbidity population or in a population that then also have a cognitive impairment or what have you, so it is sometimes really hard to apply the evidence, and I think as much as we try to sometimes, you need to just work with the best that you’ve got and put that together with your experience and the experience of those around you whereas, perhaps, some other clinical areas of when they’re a little more black and white, easier to apply that, you know, strong evidence base, and I think of that often when I think of things like we have a lot of evidence for our role in COPD patients. That’s all well and good when it’s a clear-cut, you know, younger person with COPD, no other -- multi-morbidity, come to gen med, what levels - they’ve also got a touch of, you know, fluid overload because of their CCF, and they’ve got a cognitive impairment and, yes, they had some, you know, exposure to this, you know, this many years, and it’s not straightforward and the evidence doesn’t appropriately - you can’t just apply it literally, but you just need to kind of work with it and look for the links that you can, and I think that’s also really hard for junior staff who, you know, can’t always see the difference or you think, you know, what’s the evidence for physio in pneumonia? Well, when you’re - are you talking about someone who has got neuromuscular compromise or someone who has said he - there’s a very blurry grey kind of area that exists in general medicine and with patients who have so many bits and pieces wrong with them. I’m not sure I answered that question very well.

## I think it’s a really complex area to work and I’m intrigued by how different people kind of reconcile that because I do see people really struggle with that.

### Sometimes I think - and, yeah, I - in my own practice I take it back to I just need to treat what I can see, I need to figure out - you know, going back to almost what you’d say to a student, you know, “Do your assessment. Figure out what your problems are and then treat what you see rather than getting caught up in what you’re predicting should happen or, you know, like, the trajectory that you’re expecting, just treat what you see”.

### No. But, you know what, I think my problem is this and I treat it with that and it’s improving, that’s pretty good evidence. Like, you know, in this, that’s anecdotal evidence that this is improving and at the moment that it stops, you need to find something else, yeah.

## Is that your own kind of little - is that - and as a team, perhaps, a little sort of person-centred PDSA cycle?

### Perhaps.

## A little bit like -

### I think we all work differently in our heads. Physio students are taught to do problem lists, which are like a written table where they write down, you know, the problem, the patient is short of breath for example, and then what are the possible contributing factors and how would they test for them and then how do they confirm them, and if it’s confirmed, what would they do, and they have to hand these into their supervisors, and I think as clinicians you, obviously, move away from writing it down on a piece of paper and you just kind of do it in your head at the time.

## That’s your process, yeah. Is that still your process?

### Depending on the patient. I think there’s some where I become more structured than others. Others I think it probably comes a bit more naturally by this point, especially having worked in general medicine over a number of consecutive years, yeah.

## Yeah. It’s a lot of knowledge that you’ve gained over that time.

### There’s still more.

## So what’s your workload like?

### So for me personally I probably split my day into either somewhere between 50 to 70% clinical work and then the rest of it is non-clinical, management, supervising, leadership kind of stuff. So in my - and it depends day-to-day. There’s some days where I actually probably don’t see a patient at all and then other days where I only see patients, but in an average day I would generally try to see about five patients myself, and as you - it depends on how you look at it - go - as the grades go lower, they would see more clinical load. So the grade 1s should probably be seeing, you know, depending on what their patients are, maybe eight or so in a day, and the grade 2s around the six or seven mark, but it’s an interesting point because I think if you ask me that question, that’s the answer I give you, and if you ask my equivalent position, but in a different role, in a different stream, they would actually give a different number, and I think that reflects the complexity that exists in general medicine, so probably I think the surgical senior would be like “Oh, the grade 1s should be seeing 12 patients a day”, but I disagree because I don’t think you can physically see 12 general medicine patients in a day. So I think you’ve got to acknowledge that complexity.

## And the documentation load, what’s that like?

### So we’re on EMR here now.

### So still picking up the pace on that, but just, you know, documentation review prior to seeing a patient and then post we just write notes in the EMR as well as any additional things like discharge summaries, delegations to AHA.

## Do you collect data?

### So we do statistics, as we call them. Previous to EMR they were in a separate program, which was a time-consuming situation, but now that we’re on the EMR, it’s actually - as part of our documentation, we log how long we’re spending with patients.

## Lots more consolidated.

### Yeah. So we’re then working on - and that way we get our BI data and can -

## What’s BI data?

### Like, our business intelligence.

## Sorry.

### No, that’s okay. So then we - No, then you can figure out, you know, how many - so you can look on a personal level, like, you as a clinician, how much are you doing, you can look at a program level, how many patients are we seeing from general medicine, or you can kind of crunch the numbers.

## It’s productivity.

### Yeah.

## And resource match and so forth.

### Yeah.

## And then your manager will look at that, I’m assuming, and upwards and onwards.

### Yeah. So it depends on what you want to know. I tend to look at my team’s data or if I have concerns about someone’s performance I’ll look at their data specifically, and then depending on what decisions you want to make. So if we were to magically receive more funding, you know, you would want to have a look and see where do we need to put it or how much goes where or whatever. So it can be used - it can be kind of cut in different ways depending on what you want to know, what your question is.

## And so transitioning your patients out of the hospital into other programs, what’s your experiences there? What’s that like for you, trying to make sure that -

### Access to community can be a challenge. I think one of the biggest challenges for staff is around knowing what exists out there and what is the best place for their patient at the time because there’s always new things that are cropping up or criteria for eligibility change. So in general medicine we do have a high rate of referral for community follow-up, be it physio specific in community rehab or community health, which has now, obviously, transitioned on to the MAC, like, My Aged Care system.

## MAC and NDIS and all changing space, yeah.

### Yeah, that, or thinking about things like pulmonary or cardiac rehab or then linking in with, like, heart services, which I think isn’t necessarily well done from a physio perspective as I think we’re generally unclear on as a whole - I think as a whole, you know, what can be offered and does that marry with or is it instead of, but we in general medicine and respiratory would have a very high uptake for pulmonary rehab, and I guess the challenge, as I said, with ET services, you know, differ somewhat, but it’s around referral process, around - I mean, not that we can always control it, but uptake of referral by the patient, by services knocking us back and saying that it’s not a valid referral, and then I guess by waiting list and access time and issues, yeah. So in our catchment, I don’t know what it’s like for you, it wouldn’t be uncommon that there could be six/10/12 weeks to wait to get to a community physio appointment.

## Yes, that’s a nightmare, isn’t it?

### Yeah.

## Yeah. So our heart service is very different to [Health service]. Ours is much more like [other health service] I suppose, yeah, and we run the pulmonary rehab program as well. So our wait list is a lot shorter. Cardiac rehab I’ve got no control over, but it’s always very difficult trying to, I guess, get people to think about more [0:28:08]. Like, don’t worry if they don’t exactly meet this criteria because we’re talking about a person here. It’s very difficult.

### I think an interesting challenge, and again I’m not sure if he shared with you on just here, but a lot of our access and intake is run by administration, not by clinicians, and I think that sometimes that reasoning is completely lost because they don’t - they don’t have the understanding that a clinician does, and that’s certainly a barrier we’ve come up with in the past, and funnily enough, our pulmonary rehab is … our community rehab program, not our heart, which is another interesting -

## I would much prefer it was run by a rehab … but it’s not and it’s just -

### Yeah, which is what ours is.

## Yeah, it’s kind of weird. We’re doing some work around that in the New Year, so hopefully we’ll integrate because we’ve got two different pulmonary rehabs and ours is, like, community - we do home based and centre based, and, yeah, then there’s an [Health service] pulmonary rehab, which is like a different - it’s a bit, you know, it’s very imperfect.

### That sounds complicated. I mean, ours is complicated too, and I think at [Health service] it’s complicated by the sheer geography. The catchment is huge.

## You’ve got a massive catchment.

### Yeah, and so often it’s very tricky with that kind of thing about who goes where and the processes behind it.

## What are the patients - like, do you see the same patients coming back again?

### Yes.

## And what’s that like for you? What goes through your head when that happens?

### I think it depends on how you’ve had a relationship with that patient in the past and what you know of their story. I think there’s some patients that come back and you know they’re just drastically unwell and you kind of think, like, “Oh, poor man, they’re back again”, kind of thing, whereas other times I think there’s certainly patients who are not the most compliant with recommendations for their health care and they come back and it’s almost that, like, exasperation, like, “Oh”, you know, “they’re back again”.

## Frustration. Yeah.

### Because, you know, you don’t want anyone to be in hospital.

### Yeah. So, yeah, that’s probably a challenge, and then there’s the patients that you just - they need to be there, they come back because they’re just unwell and - or they’ve got a chronic condition that leads them to that and so then it can be interesting developing a relationship with someone kind of over time, but with big gaps in the middle. We tend - my team here tend to try to provide continuity of care where possible, so often if you’ve met someone before, we try to make sure you see them again because it’s easier for you as a clinician, easier for the patient to have someone they know, which can have its, you know, pros and cons depending on how you’ve built a rapport with the patient, whether they, you know, have that clique with you, I guess, but, yeah, it can be hard having patients come in again and again. I think sometimes it’s hard to not tar them with their last admission’s brush or, you know, with whatever it is that’s happened before, and it can be hard to get services both in the hospital and out of hospital engaged with them, I think.

## To get the services engaged with them or to get the patient engaged with the services?

### Both. I think - you know, I can think of patients have who been kind of multi-presenters whom I’ve had trouble getting into an in-patient rehab bed because the inpatient rehab team are, like, “Oh, they’ve done this before”, you know, that kind of cynical -

## They shut down.

### Yeah, when, you know, in actual fact, actually, sometimes it is just needed, but then, like, it’s hard to get them to engage with services that you’re recommending for them once you’re trying to send them out into the community.

## Are there any tricks, in your view, are there any sort of skills that you develop around rapport building? Like, what do you think are the sort of key ingredients to doing that well?

### I think the patient needs to trust that you’re - you’ve actually got their best interests at heart and that, you know, there’s that level of understanding of why, you know, that you can lead a horse to water, but you can’t make it drink kind of thing. There’s no point just telling, “Well, this is what I think”, but they need to understand why you think that or why you’re recommending something, and that it’s not for you, it’s for them, because I think especially in an older population sometimes, people say “Yes” or agree to please you because they have that respect for, you know, health care providers.

## Yes, the doctor said or the nurse said or the physio said.

### Yeah, so “Yes, yes, I’ll go to that. Yes, I’d love to go to physio”, and you can see that they’re, like, “No, no, no, but I’m going to say yes so you go away”, or I think - also in hospital it’s linked with that, like, “I can’t go home unless I please them, unless I tick their boxes”, and actually -

## Yeah, they just want to get out of here.

### Yeah. You know, if I tell them that, “I’ll go to physio. Maybe I can go”, and I think, then, that, you know, that’s not the engagement you’re after, so, I don’t know. I think it’s about making - not making, but, you know, trying to help the person see what’s in it for them, for want of a better term.

## Yeah, your motivation, why are you asking them.

### Yeah, and why is it a benefit for them, and making sure that at least if they’re making a decision, they’re making an informed decision, and in the end we can all - yeah, adults who are competent can make decisions, whether we agree with them or not and, you know, giving them that power, empowering them so that they can make a decision, “However, this is what I’m recommending and that’s why”.

## So in terms of the role of the hospital and general medicine and what you’ve told me about the complexity and the timing, you know, and the repeat patients coming in and so forth, to what - what do you think is the role of the hospital in this space? You know, do you think there are constraints around how far the hospital should go or do you think the hospital could do things differently? What do you think the - ideally what would you see the role of the hospital as being in the lives of this cohort of patients?

### I think - I think some of the challenges around acute hospital care at the moment revolve around time and money, essentially resources, and I think, unfortunately, that does impact on patient care in that, you know, as soon as someone is well enough, we’re trying to discharge them home as soon as you can, or home with [0:35:13] or something like that. You just - the first sign of, “Oh, yeah, we could this”. Like, because, you know, we’re so conscious of, you know, not having enough beds, you know, every -

## Yeah, the flow.

### Yeah, the flow, getting people through, and that’s not - you know, because there’s beds sitting around empty and people want to toddle home, it’s because there is such high demand, there’s only finite resources, but I think that doesn’t always bring about the most person-centred care, and I think it’s challenging because inherently if you’re a patient, you couldn’t help but feel like you’re being pushed out, I don’t think. Like, I just can’t see any way around it, and if you - we do a lot of work with … with patient experience and the most common complaints are around patient experience, around communication, and it’s usually things like, “Oh, you know, the nurse came and told me I was going home that minute and who should they call to pick me up? I didn’t even know I was well enough to go home”, that kind of thing, and I think it’s because in silos everyone is so busy doing their own job, you know, the doctors just need to get through ward round and figure out who can go home, who they need to do this for, do that for. The nurses are so busy looking after their allocated patients that, you know, they don’t have time to answer the questions, so they say, you know, “Ask the doctors”, but the doctors, you know -

## Say “Ask the nurses”.

### Yeah.

## …

### And then allied health come and, you know, you’ve got to see your patients so they can go home. Like, everyone’s on a time schedule, everyone’s on - you know, got more work to do than they’ve got time to do, but I think that then, unfortunately, causes this kind of lack of communication amongst the team, but also with the patient, and it’s not good for patient experience, or for, you know, holistic and comprehensive care, and I think if - that happens in general medicine where we have a very good view on things. I have no idea what it’s like in other units, but I can’t imagine it’s necessarily that great.

## So how does that leave you feeling at the end of the day?

### I think it’s just hard and you always want to provide. You know, like, I would love to sit next to someone and listen to them, you know, talk about whatever they want to talk about or hear all about bits and pieces, but sometimes, you know, it’s just not a luxury that you can afford, and I think, you know - yeah, would - do we give - do we send the most appropriate referral or do we send the referral that we think is right at that time, but we don’t have enough time to give it a thought or that kind of thing. I think sometimes you’re doing the best you can, but that, you know, it’s a tricky public health system that we work in. You can’t have it both ways, so I think that’s one of the challenges. So when it comes to what’s the hospital’s role in that, yeah, I don’t know. I mean, in the end there’s always going to be more patients walking in the door, or not walking, that’s probably the problem. Being pushed in the door. There’s people arriving and they still need to keep things turning over, but do we - you know, maybe we need to look at our links to community and that pathway and how we streamline that because I also think there’s, you know, a massive difference between being here in hospital with full care and then kind of that discharge home, even if it is with a hip or something, it’s still a very stark contrast.

## A lot of resources are dropped.

### Yeah.

## Are there any patients that you - that were particularly sentinal to you that you think about and they were, like, key moments in your professional career?

### Yeah. There’s certainly patients that stick out along the way.

## What was it about those patients that made them memorable or that experience with them was memorable?

### I had a particular patient - so when I worked in rehab, which is not a fond place for me, and she in my time treating her had tried to overdose, tried to put - she used an electric wheelchair, drove her electric wheelchair and she absconded and got out of the hospital and onto the roadway and tried to get onto the freeway, and she stuck with me because she just didn’t want to hear what we had to say, which was that she couldn’t go home alone, which, you know, on all manner of facts, she actually couldn’t, but, you know, she didn’t feel like we were listening to her and we didn’t feel like she was listening to us, and she was so upset and in the end her health took a dive, not through self-initiated things, but she ended up passing away in that hospital stay, and I think sometimes you just think what is patient centred and what is person centred, but then also where is the boundary of what we do as professionals because there’s also, you know, if you - you know, you’ve still got to give a professional opinion, and you’ve got to say what you think at that point in time.

## So is that a bit of an ethical dilemma for you, just working through that?

### Yeah. I think I was quite junior at the time and I just thought it was so jarring that someone could be so affected by the recommendations made to them that they were wanting to take their own life, they were willing to abscond in a wheelchair down the freeway to get away from, you know, what she thought was just this evil place, which is pretty horrid when you think it through, yeah.

## Are there any ones that made you feel really good?

### I think there’s always some really good outcomes. I think generally that’s greater, that, you know, often it’s when you’ve put in the time and you’ve kind of done the hard yards and then you’re able to keep them away from hospital or get them home and then they go home. They’re the ones that kind of all -

## Do you get feedback later? Do you get feedback from family or -

### No. That can be a challenge, and ironically sometimes the most feedback you get is from the repeat presentings.

### Yeah because, you know, sometimes you just shuffle them and that’s that. With EMR it’s meant it’s easier to track people, at least while they’re still an in-patient. So if they’ve gone to rehab, you can at least still see what they’re up to and know if that was a good plan or not, but once they’ve left into the community, we have not a very good way - I don’t - yeah, we don’t have a very good way of knowing what happened. So if you refer someone to, for example, community rehab, even though it’s within [Health service], their notes don’t necessarily -

## [0:42:05]

### No. So you can’t see what’s going on.

## So in-patient rehab is, but community rehab sits separately.

### Yes. All our bed-based service is, but anything not bed-based, even, like … and that are not on the same system.

## So they’re probably later, in a later phase?

### Later, later, they might get scanned in, but sometimes by that point, you know, it’s not necessarily relevant. If they have a long community rehab -

## And their encounter might be closed by the time it’s scanned in or what have you?

### Yeah.

## Are they likely to come on to the electronic medical record?

### Yeah.

## In due course?

### I think it’s like a multi-stage situation. I don’t know where it’s up to.

## As to - I was reading about that today.

### I’m not sure when or what kind of timeline. It would be great in the big scheme of things.

## Yeah, ideally. Let me just check all the questions.

### No, you’re right.

## So you’ve already - patient behaviour definitely does change the interaction, doesn’t it?

### Mm.

## So just lastly, perhaps, what do you think the patient - you know, in an ideal world, what do you believe the patient’s role is in their care, in their interactions with you, your colleagues, your team?

### Well, I think ideally, you know I think it’s just about buy-in to their care and honest engagement and, you know, I’d rather a patient say, “I’m actually not going to walk with a floor frame, so don’t” -

## Don’t bother.

### Yeah, than to be like “Yeah, yeah, yeah, yeah”, and then not do it.

## Not do it, fall over and come back.

### Yeah. Because you’d rather just deal with what’s in front of you than thinking “Oh, this is great”, and I think sometimes it’s around communication goes both ways because I also think certainly there’s a lot of fault in poor communication in a hospital setting, but sometimes patients and their families don’t also help us out and that makes it challenging. I think, you know, that classic seeing it from someone’s else’s side or wear someone else’s shoes, yeah, would be interesting, I think. People’s perceptions of what public health is and what it can provide are often challenging to deal with.

## Expecting more, perhaps, than what is available.

### Yeah, and it’s about how you manage that. So we talked on our ward about, you know, shall we have a brochure saying what is general medicine? A lot of people come into general medicine and say, “You’re telling me I’ve got heart failure. Why am I not being seen by a cardiologist?”. Well, that’s just not how it works. You know, “I’ve come in with pneumonia. Why am I not being seen by a respiratory physician?”. That’s not how gen med works. Like, you know, we get consults for certain patients, but only when we can’t manage it with our own physicians. So, how do you set that expectation?

## So they’ve got an expectation of a specialisation?

### Yeah, and I think that’s probably one of the biggest things about general medicine, not just for patients, but for staff as well. Like, you know, how do people perceive general medicine.

## How do they, do you think? What’s their identity because we have this discussion as well, yeah.

### I think from the inside people, as in like myself, will tell you that general medicine is diverse and it’s this, that and the other, and all positive things, but I think there is a poor perception of general medicine and -

## Understanding what it is?

### Understanding what it is, understanding what you can do. I think - I can’t speak for other professions, but I certainly know I would have colleagues who probably think I just drag a few grannies around all day. You know, it’s not just walking old people. Like, there’s more to it than that and more complexity, but I think it’s often seen as an easy field.

## Really?

### Yes.

## I would say the complete opposite.

### So we have grade 1 rotations, so our junior staff rotate on a four-monthly basis, and often we get like the new graduates and the junior staff in general medicine, because gen med is easy, it’s not specialised. You know, it’s got less specific skills.

## Isn’t that extraordinary?

### Yeah.

## I would say for that very reason, it’s the opposite. It’s the other way around.

### Yeah, but how you go about explaining that to someone is just, you know, I think people - it’s certainly not gen med certainly doesn’t have, like, a sexy image. Like, it’s not - yeah. I love it, but I think -

## Just as well.

### Yeah, I know.

## It sounds like you’re the right person.

### Someone’s got to.

## Is there anything else you’d like to add?

### No. No. I think it’s just about your kind of bigger - these days there’s so many people who come in with some many morbidities, that it just makes things so much less straightforward, and having people understand how they all interact and how the care providers interact is just a massive challenge, I think, and going forwards I think it can only get harder as we have an ageing population and as public funding is more and more stressed, I can only imagine it’s going to get more difficult.

## Well, it’s not boring, though, is it?

### No, and that’s another thing that’s great, but I think if you are - did a kind of quick poll of a lot of people, a lot of people would say, “Oh, general nursing, oh”.

## I know they do. They’re so wrong.

### Yeah, I know. You’re telling me.

## Great. Well, thank you. I’m really so grateful for your time.

### You’re welcome.

## They’r very, very lucky to have you by the sounds of it. You’re so passionate about it. You know where to find me, my contact details.

### Yes, of course.

## If you’ve got any questions or concerns or what have you or if you would like to add anything.

### Yeah.

## I’ll get the interview transcribed and I’ll send it through to you to check and contact me any time.

### Yeah. No worries.

## Thank you so much.

### You’re welcome. My pleasure.

### 

[End of Transcript]