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| Alfred Health, Monash University - Felice Borghmans | |
| **Transcript:** | Interview SENSITIVE: Personal |

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| File Details | | | |
| Job Name: | Felice's research | | |
| Participant pseudonym | Fiona | | |
| File: | Mins: | File ID: | File Name: |
| 1 of 1 | 37 | 24393 | P3S1.mp3 |
| Total Minutes: | 37 recorded minutes | | |
| Date of Recording: | 13 March 2020 | | |

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| Speaker Index | |
| Identifier Name Role | |
| **Bold Content:** | Felice Borghmans, student Interviewer |
| Plain Content: | participant 3, participant Interviewee |

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## So we will start recording, and this recording, it gets sent immediately to eScribe and I save it on a secure Google drive and then it gets deleted as soon as I have the transcription back.

## Alright. Are you happy to start?

### Absolutely.

## Perfect. So maybe just start by telling us a little bit about yourself in terms of your role, what you do and where it takes you in the hospital.

### I probably bring many, many years of experience. I’m probably reluctant to say how many, but, like, maybe 27/28 years, or maybe longer. I’ve had heaps of acute experience in this health network, I’ve also had community experience in this health work, community rehab, Better at Home [geriatric evaluation, management and rehabilitation at home] and also have worked in another network at a major probably competing hospital when I was probably a bit younger, in the acute setting. So I’ve always come from health.

### My original training as a student, as a social work student, was in health. I train[ed] very specifically in drug and alcohol, AOD now it’s called, with a mental health focus, and then went straight into health into an outpatient-type clinic environment with AOD. So high risk, high complexity, working very closely with an allied health focus, and also had access to psychiatrists at the time, local doctors and even, you know, even legal representatives. So we have a network that we work very closely. It was quite an interesting environment.

## And this is where you just started?

### Yeah. I think my parents thought I was mad.

## It’s full-on, isn’t it?

### Yeah. I didn’t think so at the time, but that was my massive interest, and it still is.

### I’ve actually done a little bit of other work on the side. Like, I’ve actually worked for the health department, did a little bit of research, you know, and I’ve done little roles along the way because I just was trying to find my way, and I found myself back into health because I’m very much - I’m very interested in the clinical work, and probably since coming back, before I came back, I think, to this network, I also did my master’s in social work, but since then I’ve also acquired my accreditation for mental health through the ASW, and that requires me to maintain a level of education and a level of points to maintain my accreditation. Well, to receive it first of all, maintain it, and so, therefore, I have to - I pay for external supervision, so I’m very committed in being the best clinical expert I can around what I will say are co-occurring complexities, and they are really the intersect probably across - because we see health in very much a silo perspective, from a systems perspective, but people present in a co-representative way. They bring to us a dynamic of issues, and I think it’s really important that I have developed my skills and learned to understand people from a - I would call it a psychodynamic brain science, trauma-focused oriented work. So that’s really my speciality now.

So, look, I’ve worked really hard to acquire that accreditation. I work really hard in paying financially to upkeep the knowledge and the area and develop it. So I’m really interested in the psychotherapeutic world now. So that’s probably something maybe in the future that I might look into, but translating that to work has been absolutely, you know, magnificent for me, because I am really clear about the patient-centred work because it’s a set of values around objectivity, boundaries in how I need to manage it and also reframe people’s presentations when I’m sitting in an environment where it may come across as overwhelming for other clinicians, how do I help educate them to reframe in a more positive way and provide education for them.

So I see my role as dual. It’s not just working with the complexity of what the patient brings, but how do I support, and I’m not talking about other social workers because that’s - I see that as my given, but how do I support other allied health colleagues and provide education and support to them so they can actually manage work which seems overwhelming at times, and probably difficult to manage, and sometimes may be unable to manage, all of that. So I think I’m always learning is what I’m saying.

I’m really interested in the leadership role now and further developing that, but I would like to maintain a clinical focus, so, yeah, and it’s been, like, the roles have been really interesting because I’ve been able to, I guess, experience and provide the opportunity to provide leadership to other social workers, support, debriefing, provide them with current evidence, you know, clinical interventions about what’s relevant around trauma-informed work, the brain science industry in terms of what, you know, the neuroscientists are talking about how to manage hypervigilance, you know, dysregulation and how we intervene and use a set of tasks. I think that’s really interesting to provide that education because I think in providing education, and I know from other research, is we actually then manage burnout. So that’s - I see my role as dual, as a sort of educated teacher, support, debriefing, and don’t wait for supervision, but talk about complexity in that sort of supportive, educative way, but I need to be up-to-date with all of that, yeah.

## Right. That’s a huge amount of thinking you do about your role.

### Yeah.

## Which is fantastic.

### I’m very passionate about it, Felice.

## Yeah. You’re totally invested in it, and particularly in that complexity space, and I’m really interested in what you’re saying about, you know, the knowledge and its relationship to burnout. Can you talk a little bit more about that?

### Yeah. So what I found really interesting is I think when - I think it’s the leadership’s role/responsibility to build a culture of safety, and away from the prescription model which offers a culturally opposite view to the health setting because - which I understand. There isn’t - I’m not being critical when I say that it’s just a different culture. My training is very different. It’s - it doesn’t come with a prescription pad, because we look at the individual in the context of their environment and family and relationships, so it’s not just the individual one-to-one with the therapist. We see it as a systemic issue, individual, family and then systems. So from that perspective, I don’t have all the answers. I have to inquire to then build to understand people’s resilience.

## Of course, yeah.

### And then from that I have an understanding of how to reinstate people’s autonomy. So coming from that, I think, education, translating that concept is really interesting as a leader, how do you do that and support staff, because we have set supervision, but I don’t believe in just leaving supervision for once a - one month that you require. I think that you have to have - breed and promote and encourage safety, and how do you get a team that comes together to actually openly talk about what they’re uncomfortable to talk about, what they’re struggling with as clinicians, when you have a variety of skills in the room?

## When you talk about safety, do you mean staff safety or the patient -

### Staff, staff safety.

## That’s emotional.

### Their emotional safety -

## Yeah, I see, sorry, yeah.

### - as professional clinicians because there are gaps in our knowledge, and to talk about gaps, not on a one-to-one level but in a group environment is actually quite overwhelming, so how do you do that? So I think the way I do that is a little bit of humour, I encourage some clear structure, and you can’t break the structure, so there are some firm rules, but there is also some humour, but there’s also an opportunity for others to provide the answers, not just me. So I encourage other senior workers or other specialist workers or other people that have specialist knowledge or other new information that’s been discovered by somebody else around systems or new pathways around systems, or new research around whatever, it could be clinical interventions, to promote that in the team, even though maybe the purpose of the meeting might be just about discharge planning.

## Yes.

### So how do I incorporate education, you know, and support around that? So I think that’s really important, and then through that I think you build trust.

## You seem to be able to do that. I mean, because your knowledge is so vast now and your experience is you seem to be thinking about that all the time, but does that come somehow naturally to you now when you’re in that space, in that zone working around a debrief or, perhaps, discharge planning? Is that kind of - do you naturally use those as opportunities, not just to address problems, but to teach?

### Yes. I think - I think the beginning was really hard and now that the Jeanie is out of the bag about, you know, there’s a clear structure here and we have to perform and we have to answer to [Fiona’s] questions, but it’s also done in a safe space and that others contribute, and also the other thing that’s really important, I think it’s important for staff to know what the story is, when I need the information. It’s - I just don’t need it to fill in, you know, the data sheet or just to report to Long Stay or just to report to [Hospital admission risk program -HARP] because they’re saying “no”. What is it that you’re - you need to tell me A, B and C because we need to qualify what the rules are in terms of, you know, eligibility, but also what the barriers are for discharge and have we done everything or are we still doing and where the hold-up is. So the story is important, I think, for staff rather than half the staff and just wanting information. So I think that’s another thing that I’ve learnt, and I’ve been really clear with staff, aside from all the other stuff that I might do, but that also has been the key - I think the key thing, I think, and it’s probably a research project in itself. I think it’s the key thing because once I maybe do that, when I’ve done all the rest, that seems to be the eye opener, because then I will say, you know, “I’m asking you five questions and I’d like the answer. If you can’t do it now, can you do it after the meeting? Because I actually need to go to this meeting and in that meeting because I know exactly what I’ll be asked”, and I would like to be able to know for myself because that gives me a clear indication about what could be done or not be done because then I could add to the discharge pathway or not.

So the other thing about the discharges with complexity is, and this is the biggest challenge, I think, in the last, I think, five years, is we’re looking - I call it - now I’m starting to use words like “algorithms”, you know, and I’m - you know, I’m not a mathematician, but, like, when I start saying “beyond dual pathways”, and then an algorithm with each pathway, it’s really, really complicated, because we’re talking about decision-making psychological, but then we’re talking structural problems as well. So there are not just individual decision-making problems that are around the one-to-one relationship with the patient, or it might be the family which is another dynamic, yes, we know that, that’s traditional, but also we’re talking about now system breakdown issues that don’t cross-fertilise, but they are solo but they work in an algorithm way, and I think that that’s really complicated for not only social work but how does even social work, our social workers simplify and synthesise that information when we’re standing at the journey board or, you know, we’re explaining it to our peers. It’s actually not an easy concept.

## So why do you - why do you think - I mean, why do you think -

### So what I’m saying, sorry, is, therefore, that’s why when I look at it like that, I ask lots of question and staff go “Why is she asking me all those five questions?”. Because this is the way it actually plans out.

## You’re trying to match the information to the world?

### That’s right.

## Yeah.

### And that our organisation is aware of that and they will be asking the same questions, and then is there anything as a team that we could add in to create another pathway.

## Do you think the world is well matched, the world of information that we need is well matched to the patient?

### What do you mean, the information?

## So you’re talking about different services have got different decision-making algorithms around eligibility, access, so on and so forth. All of them in my experience kind of are about boundary conditions around the service rather than meeting the needs of the patient in a sense.

### In a sense, yeah.

## I mean, they have -

### I think we try, but we’ve got programmatic guidelines and funding - I think restrictions, yeah.

## Yeah. So some of them are about making sure that there is access for people that need it.

### That’s right.

## On the other hand, but - so you’re working in that world. So how hard is that to actually meet the needs of that world and match them to your patients’ needs?

### Extremely hard. Extremely, extremely hard, yeah.

## How often - I mean, what’s it like, would you often control access for patients that don’t fit neatly into any particular algorithm or they might fit into two, but not - is that a common thing?

### It’s becoming - it’s an emerging - it’s becoming an emerging thing, but, look, you know, because I’ve been around a little - a little long, like, for example, pre-NDIS there was a service system there that probably matched what NDIS is trying to do, but it was slower with less funding. What’s transpiring are the same themes recurring except in - I call it in a rebadged program, because it’s actually, you know, it’s actually a government program that’s contracted out, so it’s a contracted out -

## Yeah. It’s a private-public relationship, yeah.

### Yeah, and I’m familiar with that because if you’d been in health, those sorts of - kind of, you know, contracted out programs from the department are not a new thing. They’ve been occurring for the last 30 years, you know, so the themes are very similar, I think, but they’re becoming more, I think, convoluted and complex because of the way they’re managed, the funding is managed, so, you know, it’s unclear now who you make complaints to for vulnerable people, you know, under the NDIS program when there’s, you know, potentially conflict of interest. There’s a whole range of ethical dilemmas, I think, now, and I think staff get confused about that.

## There’s a lot out there, yeah.

### Because there’s also not a structure to actually escalate it to address, you know, the potential abuse, the structural abuse that reinforces the abuse. So it doesn’t do anything about it. You know, that reinforces the continuation of the person being vulnerable and exposed to abuse that continually occurs.

## Yeah, because of a structure that’s in place in terms of escalation and flexible responsiveness and -

### None of that, yeah. There’s limited ability to do that, yeah, because it’s client driven but -

## And it’s algorithm driven.

### That’s right, that’s the other thing, I think, you know, the body that’s going in to help the patient, who may be also abusing the patient, not doing their work as well. There’s multiple players of problems. For example, there’s that, and then, you know, how do staff manage that? It’s a systemic sort of issue. I think, you know, the disability, you know, inquiry will help with some of that, I’m hoping, and will maybe clarify some of those issues. I think that -

## Yeah, and in aged care.

### Yeah.

## Hopefully.

### I think that will be -

## It’s fraught, though, isn’t it?

### But, you know, at the moment, you know, Felice, we’ve just had another realisation, you know, is that aged care, the aged care system will no longer be able to assess people under 65 if they’re heading down NDIS because the government made it really clear that they don’t want any younger people in aged care facilities by - I think it’s 2022. Yeah, 20 something, 2022, and then by 20 whatever, nobody - it was under 45 in the first instance, and then by the end date, you know, nobody under 65. So at the moment what’s happened is they’re in transition to developing those protocols, but at the moment when they’re exposing that transition, and we’ve being told that [Aged care assessment teams – ACATs] can no longer sign off on aged care, even if the patient wants while they’re in NDIS to fund a destination, so that pathway is closed, and there’s nowhere else for us to go. So for somebody who is not actively dying, maybe not hospice, but has a - you know, a health injury or multiple, ended up bedridden and maybe had a short lifespan of less than 12 months, you know, cannot go home, can’t go to an [special residential service, SRS], can’t - you know, where -

## You’re blocked, you’re roadblocked whichever way you’re turned, yeah.

### So that’s the structural barrier now, and let alone if you might have a family who might be feuding with us about wanting A, B or C or wanting something else, yeah.

## It’s massively complex, isn’t it?

### Yeah, it’s really - and these are just, you know, systemic issues, and if I talk about, you know, the most vulnerable out there who are homeless, who are using drugs, who have got a mental health undiagnosed and extremely vulnerable to, you know, being abused, how do you manage that in terms of access to services, one, but also get compliance with the patients about, you know, minimising risk, yeah.

## You need good luck with that.

### Yeah.

## Yes, I know that, I know what you’re talking about, yeah.

### There’s the system in all its complexity and then there’s -

## Yeah, definitely.

### - the patient complexity.

## Definitely. So in that world that you work, which is - like, there’s so much going on in it.

### Yeah.

## And, obviously, so much going on in your mind. You’re clearly, like, tuned into the whole global picture of this. How do you deal with that yourself on a daily basis? You talked about knowledge, having the knowledge to understand the system and how to work with the system, but you’re still sitting with the problems. How do you personally cope with that?

### So a couple of things. I think, you know, one of the reasons I’m here, I’ve had some really fantastic leaders, I have to say, Felice. I didn’t want to work at the [health service x] at all because I had already worked - no, I’m being very serious, but, look, after 17 years, why am I still here? I actually tell this to, you know, new graduates. I worked in a major network in - I didn’t like it. I hated it. The difference is that culture was a very different culture to the [health service x] culture. This is a can do culture I work in and no matter what the problem is, from doctors, to surgeons, right down to, you know, allied health and myself, is what can we do even though it looks like the most unbelievably unable thing that we can do, it appears that we can’t do, so it’s a can do, so I’m surrounded by this culture and then this department that’s really supportive.

### So I’ve been supported by, you know, the medical unit to go to conferences, to present, I’ve been supported by my manager, [Name], to present, I’ve been supported by [Name] you know, funding some of - you know, contributing to conferences, to some of my - I mean, you know, I’ve been supported by being asked, “What do you want to do, [Fiona]?”. You know, “Would you like to do a bit of this and a bit of that?”. “Yes”, or I said, “ Can in I do a bit of this a bit of-”, ‘”Yes”. So I’ve been exposed to different roles, I’ve worked in long-term chronic illness, you know, in respiratory, I really enjoyed that, I worked in the transplant world, pre-transplant/post-transplant, I worked - I’m on the after hours emergency you know, roster. I love that. I loved ICU work.

### I think that’s one aspect, because I’m supported, and the culture, and I’m appreciated, not just by my own discipline, but by others, and I really enjoy that conversation. I feel like I’m able to offer and they can accept. It’s like this equal relationship. They give me what I want when it’s medical from nursing, doctors, from non-medical to maybe psychosocial, and it’s all, you know, acceptable and acknowledged and respected. I think that’s just amazing.

I think the other thing for me is the education for me to be able to go away, you know, and have supervision outside is really helpful for me. It’s helped me focus on what I wanted to do because that’s really helped me find myself. So that’s been a long journey. I’ve had to work on that, and I think you have to be invested to work on that to find your sense of who you are and what you want, professionally I’m talking about, and being comfortable with that, and the other thing is I think I get great pleasure from being able to support staff, other social workers, and when I get feedback and I’ll check in and I might say, “Have I been a bit too harsh with asking too much?”, because I’ve asked the five questions. You know, I might laugh about it, you know, and then I - I even laugh about myself. You know, my - you know, the inquisitor or the investigator. I say, “I know I come across quite hard sometimes”, and we all have a bit of a giggle, so I think humour - and staff will tell me, you know. So I think if I - you know, I check in. I check in, I like to educate, I try and look after myself by going outside to have supervision. I get supervision from great people that I care - a lot of it is process and I need that because things are changing all the time and communication is unclear within, so I need that, and how you stay focused with, you know, trying to do the job, but, you know, [Hospital x] is a really fantastic place because what I’ve developed here is outside the social work world and outside the medical world, because when I was on the ward in acute for many years, it was very much, you know, the high-powered people and nursing, the specialist nurses, and social work here, it’s a whole different, you know, game because it’s now all the [Nurse unit managers -NUMs], it’s people like you, Felice, it’s executive. So I’ve got these relationships that I’ve developed with these senior people who are really down to earth and really invested in understanding the complexity around the dynamics of the individual and then the structure, yeah.

## Great. So I’ll just skip through a few [questions]. You’ve definitely given me a range of context of care. What makes a clinical interaction really effective from your perspective?

### Between whom?

## Between yourself as the clinician and the patient working together.

### There’s clear research on that and I’ve always had a gut feeling I’ve always done that, and that is you’ve got to have rapport. So rapport actually means -It means don’t talk.

### Just ask for the story and just wait. So if you don’t have a sense for that, because not all of us do -

## Yeah, you have to fill the gaps.

### We don’t fill the gaps, so we need to go away and learn how to do that, yeah. So I think that’s a journey in itself, you know. So do you feel uncomfortable with the pregnant pauses? Then you have to work on that. That’s something you need to work on. I think that’s really, really important, and then you check in.

### I always, I’ve got this very, very focused feedback opportunity with patients and I always - sometimes I forget, but I pretty much always ask at the end of the session, you know, feedback from the patient, what was - “What did work for you/what didn’t work for you?”, and I know. So what I feel might not match or might match, so I have to directly ask, but I have to sense it as well. So I will develop the rapport and listen, but then I would sense how I’m going from their behavioural responses, facial expressions and maybe even question it and check if I’m on track and then I will directly ask. So I’m constantly doing the rapport while I’m checking. It’s actually very complicated work.

## It sounds very complicated.

### It’s complicated.

## It’s like a process of sense-making all the way through.

### It’s a dual approach. It’s really complicated, and there is psychotherapist in America, there’s a psychiatrist that’s specifically written on this and there’s clear evidence on this, that if you’ve got that right, 80% of your work has been achieved and you’ll get the intervention you want rather than the tool you use. So it’s extremely complicated.

### Now, how do you do that with a highly dysregulated patient with a borderline [personality disorder], you know, patient who’s extremely anxious and hypervigilant, you know, codes all the time [medical shorthand for code blue] because they’re hyperventilating? Yeah, you can, and there are techniques, and maybe you need to adjust yourself, but you can. It’s very hard, though.

## Yeah. And when you say - I think rapport is incredibly important, and one of my concerns is, you know, social workers, perhaps, have a little bit more time to do that, but they’re run off their feet too. For teams, I struggle to see them having time to sit at the bed and talk to the patient and naturally get to know them, have a listen to what’s going on in their lives. Do you think that we do rapport well generally as a set of services?

### I think - look, what I’m trying to say is rapport isn’t something that comes naturally. I think you need to be aware of it and be trained in it. I don’t think we’re trained is what I’m saying, so we need to be trained, and I don’t think - look, it comes with - I call it the talking therapies, so social work, psychology and psychitry, yes, we’re trained. You know, I’m trained as an undergraduate how to do this. I had family therapists training me. You know, like the most skilled people at the time were training me. I was told where I was going wrong as a student, so I learnt very early on, you know, early along.

### Now the research is really clear about what we need to do. Psychiatry are the same and also psychology are the same. We know, but I think then to translate that to other areas, like, medical, nursing and other allied health, I think they need to be trained, and I think that’s where the difference is, and maybe they don’t need the same level of training because it’s about communication skills and how you communicate very sensitive topics and how you, you know, measure and how you apply and what you look for, but if the basic is done, I think it’s really important, just the basic sort of key themes, because the other thing that I think we get wrong is we assume that the person will disclose because they’re in hospital and it’s on our terms. No.

### No.

## We know that for sure.

### We do assume that, so we’ve already started on the back foot, I think, with patients, and I’ve noticed that in the acute world and I’ve noticed it in my previous, you know, acute role, but also in my D and A [drug and alcohol] world as well. Just because I’m a D and A worker doesn’t mean I can directly go in there and ask everything about frequency, use, how much. No. I’ve got to have that rapport. What is it that you want and how can we work and do you want - so I’ve got to - it’s almost like requesting for permission for disclosure. So “Why are you here and what can I do for you?”. So it’s the same approach, I think, for the person in their bed. Okay, they might be really, really sick and they’ve lost their sense of independence, but I have to ask for permission and that’s it, and I don’t think we do that. So it doesn’t have to be as complicated as what I’ve just described, but we need to ask for permission. I don’t think we do that well, Felice. We don’t even ask for that.

## And I think there’s the issue of time as well because some of this takes a bit of time.

### No, I think it’s strategy.

## Strategy, yeah?

### Yeah. Look, I think there are different tasks that other allied health need to do and nursing, and there are different tasks, say, for social work because it’s all communication. We don’t have to do practical things. I think - see, I see OT and physio nursing really complicated because they have to do tasks, so how do I get - I think that’s really complicated because you’re asking a patient not only to think about it, but now you’re asking them to put it into practice. That’s actually changing their thinking. That’s actually a bigger challenge.

## Do you think?

### Yes, I do.

## Interesting.

### Because I have to get them to shift their thinking not only to thinking about it but what are the steps to achieve that task, which is a change from what they are currently doing.

## Yeah, and are you talking in that sense about things like recovery?

### I think we don’t understand the dynamic is what I’m saying.

## Yeah, right, okay. Because when we talk about behavioural change in, say, a person with complexity and we’re wanting them to sort of be more adherent to their medications and things like that, that’s very difficult.

### Of course it is.

## So is that the kind of tasks you’re talking about?

### Yes, absolutely, yeah. That as well as, you know, generally getting out of bed and participating, walking down the, you know, down the hallway and doing 2 metres when they’ve got a broken leg and they’re too scared to get out of bed, yeah.

## Yeah, and they’re old and afraid of falling again and all of that.

### That’s right, yeah.

## You’ve got a complicated mind, Mary.

### I’m sorry.

## No, it’s great. It’s great. So we know that chronic diseases is a very large and complex problem in Australia, and globally, I guess, and social determinants have a very big role in this trend.

### Yeah.

## What do you feel that the hospital’s role is in terms of working around that space around the social determinants of health?

### It’s a big question.

## Sorry. It’s just a very - yeah, just before -

### No, it’s a big question.

## Yeah.

### Because I think the social determinants aren’t really attached to health. I see them as a system issue. You can’t separate health and asking health to be responsible for all the social determinants, low income, access to, you know, housing, access to, you know, my methadone, my pharmacy, access to income. I think that that’s quite unfair and I think it’s disproportionate an expectation for health. I’m not sure if that answers your question.

## No, that’s fine. No, I just want to get your sense of what you see because, of course, services like HARP, they straddle that.

### Of course.

## So they’ve got a foot in both - and you do too.

### Of course.

## Yeah. So do you feel that, really, those things sit outside of what we should be doing as a health service for patients or how do you view that?

### I see that as a pathway and I see it as - I kind of see hospitals and home transitions. That’s how my mind works about it. So people live in the community and that’s their life and they transition into health and we need to help them transition back. So their actual permanent lives aren’t health. For some people that’s not quite right because I have worked with extremely chronically ill people who, you know, 10 years ago would have been not surviving at the age of 30, 35 and they live life differently, and I get that, and hospital has become part of the parental system. I think that’s different. Some of the state-wide services are like that, and I think that there is a place for that and that’s absolutely necessary because we are, I think, in that space changing so scientifically quickly and advancing so much that psychologically we haven’t even made the adjustment to it.

### It’s really quite a fascinating medical scientific world to work in. It’s not like 10 or 20 years ago, the HIV area, the Hep C area. It’s amazing what the achievements are today and how that’s transformed people’s lives to be able to live with, you know, a chronic illness that they couldn’t live with 20 years ago and they can now and reach the milestones and, it’s, like extraordinary, absolutely extraordinary, and then if I throw in sexuality and fertility, extraordinary advances. We haven’t even caught up.

### So I think that there is a space, but that’s quite specialised, I see that, and then I see the specialist sort of, you know, the surgeons doing stuff in ED, and I think we need that, and I think that’s worldwide, international, you know, crosses borders, you know, across states, and I think we need the space for that and people come from wherever, but I think generally I see there’s a transition, and I think hospital is only a transition. That’s how I view it in my brain. So I come from the perspective that, you know, wherever somebody comes across, it’s non-judgmental and how do I maintain that objectivity, because we all bring judgment.

## Absolutely, yeah.

### But how do I balance myself? Somebody’s homeless, they’re on the streets and that’s where they want to be and yada-yada-yada, yes, they’ve got, you know mental health, yes, they’ve got services accessing, but they’re minimally compliant, yada-yada-yada, but how do I respect that and balance that risk with what somebody wants, which sounds like a really poor decision with then all my colleagues, and I sit comfortably with that because my level of risk [tolerance] is so high, that it sits so uncomfortably with my other colleagues, how do I help my colleagues, you know, re-align themselves so they’re not being subjective?

## Yeah, or paternalistic.

### Which is paternalistic, yeah.

## Yeah.

### I think that’s a huge challenge and I think the hospital has some responsibility in that to provide education. I think education is the biggest tool and weapon to manage, how to better manage patients, how to manage staff burnout and also to acknowledge the staff struggles. That’s what I think.

## Great.

### That’s what I really think.

## I think that’s a good note to end on, [Fiona]. Is there anything else you’d like to add?

### No.

## You have got a very full mind. Amazing. I love it.

### Do you?

## Have another biscuit.

### No. I’m just going to finish my tea.

## Thank you.

### I really enjoyed it, yeah.

### 

[End of Transcript]