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

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## So we’ve gone through all that. So basically what I’d like to sort of get a sense of first of all, if you could just kind of describe what your role entails, and sort of how you work in the organisation really?

### Yep. So I am the clinical lead for the Community Health and Outreach Physiotherapists, so it’s a leadership role clinically. I’m a physio and currently I’m the operational team leader as well.

## Got a few hats.

### Yeah, for the Early Intervention and Chronic Disease team.

## Right, okay. And in terms of the complexity of that role, that’s a lot of things to juggle, what’s your work day like?

### The operational team lead is just an acting role for a very short period of time, so luckily that’s – this year and last year, or for the last 12 months, I’ve intermittently stepped into that role. But for this little period of time it’s quite skeletal in what I need to do because it’s just a much smaller time than previous times. So really, it’s physio-ing and clinical meetings, and I get allocated two days to the leadership role and three days to practicing. So, it’s quite nice delineation. The physio role’s quite standard times but with the clinical lead there is quite a lot to do and determining – as I’m getting more experienced in the role, being able to determine what is clinical and what is therefore not clinical, operational, and needs to go elsewhere.

But can you just say your question again actually?

## So in terms of the complexity of your role, what is this experience like for you. Do you find that you get the supports you need? For example, are the policies and protocols and all that kind of thing that sits around it, is all that sort of – is that your framework? How do you actually organise your role?

### Yeah. I think the clinical lead role is complicated because first of all I came into the role quite inexperienced, so often clinicians get given these leadership roles and they’re not businesspeople and they’ve not had leadership roles before. So I really want to do – I really want to support clinicians as well as possible. I have no skill in doing that because I’m skilled in physio. So for me there is a framework and there are supports, but it’s difficult learning how to fulfil that role to the benefits of people that I support. Partly because I think initially I took on everybody’s – like, how can I support you, and everybody told me you can support me with all of these things. And I said, oh fantastic I can support you in all of these ways, and went off and did them, and then really was quite overloaded. So now, having a little bit more experience, I want to empower people to have the skill themselves. So I’m trying to say, well what does that look like, be a bit more discerning, ask can we do it together, can you do it on your own? So I think those skills in how to clinically lead, how to bring out the best, how to support and teach your team, they’re the things that I’ve lacked training in and had to learn by doing it the wrong way initially.

## That’s a really interesting. I’m really glad you raised it because you’re right, so many clinicians just get – they’re great clinicians and they’re just like, oh you’re a great clinician, that must mean you’re a great leader. They’re two interrelated but different skill sets, aren’t they?

### Yep, very.

## And do you think there’s a lot – do you think there’s adequate actual training and knowledge within Health around that kind of thing? I see a lot of short courses and quick fixes, but what are your thoughts around that? Do you feel that we have enough available within our academic resources and in organisations for that development? And do you think it’s done at the right time, I guess I’m saying?

### Probably – there’s a few factors, so probably a time thing, you know, because you’re given the role and then you’re sort of – then you probably have a few stumbles and then become better. So you’re retrofitting your skills.

## Yeah, learning as you go.

### I think also time allocated to the job in that the supports I’m given, on paper are extensive, so I can go to this person, this person, and this person, but we’re all busy. In normal times we’re all really busy so those meetings get cancelled and there’s a sense of could I solve this myself? Do I need to bother that even more senior person? I don’t want to show that I’m not able to do it. So I think the support – it looks like a lot of support on paper but in reality half of them goes by the wayside.

### But I also think that potentially because of those things actually – I’d say 50% might be that the skills don’t get transferred over. The 50% might be also because it’s not until you do the job and realise that you’re going to need to change your strategy in the job. Because I don’t think I’m a particularly good leader, and the way that I’ve tried to lead is by showing that I’m happy to roll my sleeves up and do the same work as everyone else. But I don’t know whether that’s the right way. So as I’m getting more experience I think a better way to lead is as I’ve been saying, to sort of think how can I support you? How can I teach you those skills? How can I prepare you for being a leader? So that means not just saying, yep, just give me a list of things you need doing and I’ll do them, by saying, you know, can you maybe give me a bit of an – give me a bit more information about what you need and what that would look like, so they’re going through the processes. I’m having to learn that later in the piece because I sort of think, oh, I’m doing all this work here, thinking I’m being a good leader because I’m taking your work off you, and your non‑clinical work off you, and you’re sort of upstream things off you, but really I’m not…

## Not capacity building kind of thing, yeah.

### Correct. So I think that bit’s not been explained or supported as well as it could be, but partly because I didn’t know that was a skill I needed. So it’s partly that I’m not asking for it, and partly that it’s not there.

## Very interesting. And do you think this is a common experience in Health with clinicians put into leadership roles? Or do you think this might be unique to this particular scenario?

### I think it probably is common, it probably is common. I often think all my peers are so much better than me.

## I don’t think you’re about the only person that experiences that thought. We all do that.

### So I often look at peers who are in leadership roles and think they’re so naturally gifted at being leaders, whereas I often think I’m someone who needs to work at it. It doesn’t mean I can’t acquire those skills. I believe that I can acquire those skills and be a helpful leader, but I don’t feel that I, in the first instance, fall into it naturally. I think it’s something that I probably work hard at as acquiring. So I think there’s people in my world that just naturally have some great leadership qualities. So I think yes it’s missing in lots of people, but lots of people I know have it in abundance naturally. It’s more for those people that perhaps feel they need to go home and study those skills even though it might be more common [cross talking 0:09:05] feel they don’t have them, if that makes sense.

## Great. A great way to start, it’s so interesting, thank you.

Alright, let’s get you out of that space, and let’s start talking about patients. So you would see a lot of patients with complex diseases and chronic conditions, yes?

### Yes.

## So what is it like? So if people with chronic disease present frequently and in ways like you think oh my goodness, if you’d only done that, or if you’d only done that. And they do – you know, you see them time and time again, what’s that like for you as a clinician? How do you approach that sort of care with that person?

### So there’s quite a lot of layers, but potentially I would stop doing physiotherapy, as in the stereotypical image of it, and I would start doing more motivational interviewing, I guess would be the collective term. So changing the way that we’re meeting to ask more pertinent questions. Being honest with the patient, so, you know, this is what I’ve experienced, I’ve seen you half a dozen times, we seem to be just going around the same issues, or we seem to have a lot of different issues that all are quite intertwined, or completely separate. What do you think’s the reason for this, and let’s make a plan that fits with you. Maybe you’re not ready. So, one plan could be for you to go away and come back when you’re ready, because we’re not changing things. Another plan might be to just collaborate together on a good plan that does feel workable to you, because maybe my plan’s only getting a sliver of the picture, there’s a big pile of the picture I don’t see, that you see. And I might ask them what do they feel is at the root of their issues, what do they feel they need, what do they feel a good plan would look like, so we can try a different strategy. So, stop the “how’s your knee?”, and provide treatment for the knee, and start talking about, you know, what’s going on? What can we do together? What would it look like? And can we turn this into a plan that’s going to take us forward?

## Do those kind of conversations happen a bit with the clients you look after?

### Yes.

## So how does that work for people with complex conditions?

### So for me, I would happily – so even in the last week there’s been a couple of complex patients and I’ve spoken to other clinicians that I can see are seeing them and said can we see them together? I’ll come to you, you can come to me, we can see them for an hour and discuss about pain and the nature of pain or talk about making a plan together. Or even co‑treating. So, if they’re coming to you on a Monday and me on a Tuesday and the dentist on a Wednesday, like, can we reduce the amount of time, or even have the same – because we are all having the same conversations but I’ve never heard how the podiatrist said it, and they’ve never heard how I said it, and we operate in silos. So can we just collaborate and sit together with the patient, or even tell the patient that that’s not possible, that we have talked together, and so we’re going to be sharing information, if that’s okay with the patient, and find ways to collaborate more.

## Can you please just, in your words, tell me what that means then for the patients if you are collaborating and planning together? How does that benefit the patient, and yourselves, the clinicians?

### I think for the patient potentially they can feel that there’s joining up of their care. And then because we’ve collaborated and shared knowledge, hopefully that knowledge so far that I’ve done this has been similar, yep, I’ve been trying to say that as well, so have I, and we’re a unified message because there can be mixed messages for the patient. So, they’re going to get a unified message and they’re going to feel that their care is knitting together a bit better, maybe not perfectly but better, and potentially reduce the amount of times they’re coming in. And potentially, with podiatry for example, because that’s the latest one I had, some of the exercises and staff management strategies are very similar to what they might be doing for their knee, because they involve the leg. So potentially there can be crossover treatments.

### I think for clinicians as well, you can feel that you’re validated because you might be saying the same message to that client and thinking I’m not getting through. Then when you hear I’m having the same issue with that patient, you think, oh, good, it’s not just me, I’m not failing the patient, we’re just needing a new strategy. So, I think that collaboration is quite reaffirming. Or even if you think, oh gosh, I got a completely different impression of this patient, maybe I should see it from – maybe I’ve been looking at it from another point of view. I’ve been quite fixed in my mindset because this other clinician’s not getting that impression at all and they’re having great progress with the patient, so maybe it’s time for me to change my view. So, all of these things, just helping to facilitate recovery, self-management and sort of empowering the patient to feel they’ve got the control to manage their condition.

## You seem to be very reflective about your practice? Would you say that you are?

### I think I am because it’s quite a complicated scenario. So, we do get people who are chronic and they’ve got potentially multiple things. And the private practice model which I’ve come from just doesn’t work. I’ve got a bad knee, come, I’ll sort out your knee. Oh, your knee’s better, go home. That just doesn’t work.

## Single system, single body, single joint issue?

### Joint, mechanical. These are sort of biopsychosocial patients and the issue is much broader. Yes, they’ve got a sore knee, but they’re also isolated, and so fearful of moving, or fearful of things going wrong with them, medical things, they’ve past history of things not performing according to the textbooks. So they’ve got all this worry about oh, it’s bound to be another failed bit of therapy so their belief in their recovery is low and they’ve got lots of things that they are dealing with, they live alone, they don’t feel supported. So, you’re dealing with a completely different set of circumstances. So, you need to say yes, you have this knee issue but educate them prognostically even with comorbidities it will do really well statistically, so you can provide lots of good education and movement is the best thing, and management by yourself, you’re more than capable and we’ll be supportive. We can be supportive by tailoring that support in a way that makes sense to you.

And to come back to your reflective – I think I’ve been reflective because I’ve tried to put a – you know, tried the same method of private practice where it’s much more – less biopsychosocial and then it hasn’t worked. And so, then I’ve thought how can it work? How can I get this person home and happy and enjoying life? What needs to change? And really I just need this broader approach because sometimes I do less therapy, but I’ve done lots of education, provided lots of good information and lots of supportive talk, and lots of we can do this together, and go and try this, and we can keep trying, and that’s been much more successful. So I’m just, in my mind, constantly thinking how can I achieve – how can I help people enjoy their lives with a complex and often, you know, pessimistic cohort? How can I get them to where they need to be? The actual issue isn’t the big issue, but it’s become a big issue.

## Because of all the history and the baggage, and the experience?

### And the low expectation of recovery. And so yes, I reflect a lot because I just wonder how can I do that? I just ask myself all the time, how can I get this person having the best time?

## Do you like that process?

### Yeah. I love it.

## I can tell, yeah. I can tell.

### And trying to find the way. [cross talking 0:18:42] What would be the right – would too much information with this person overload them and make them frightened? What about the other 10%? So, would numbers be the wrong thing to do with this person? You know, what’s the right combination of things that some people say, oh, but I’ve come for my knee, so then you think, well I have to – they want the knee, this is their – so let’s do the knee but while we’re looking at the knee we can talk about other things, we can expand, about their overall feelings, they want to have their knee attended to. So I just have to try and match the patient and find out how can we get the furthest possible with this person’s good time? How can we move as close as possible to good times as fast as possible for this person to move from their kind of point to thinking I can see that I can do well, and I can do this by myself and I think it’s going to be okay?

## And what does that feel like when you have those outcomes?

### Good, really good. And then I sort of step back, but I’m just always refining – I don’t think that I’ve, you know, finished. Like I’ve found the answer, but just constantly trying to think of that, that’s always in my mind. Do we need a plan? Do we need to chat? Do we need an exercise? Do we need a group? Do we need a – what do we need? What’s it going to be? Maybe a group isn’t as effective as my kind of exercise, but if that patient’s lonely, then maybe, you know, a nice group is fine. We don’t normally take people to those groups, but if I can go once and that breaks the ice to get them there, then I take them there for the first time and say this is Dave, this is – you know, so what little things can I do that just facilitate that person breaking down the barriers?

## Do you think your way of thinking about your role as a physiotherapist, do you think that’s a typical – like for instance, if you were on the ward, is that how the physios would think on a ward in, say, a cardiac ward?

### Maybe. I don’t know, maybe to some extent, but it’s more obvious here because you can’t – because it’s so subacute as well. I think when it’s acute and you’ve just had big surgery, then your – as the physio you’re just facilitating discharge. But you do want to take into account social history and barriers and all those things but to a lesser degree maybe.

## The drivers are different, do you think, in the wards?

### Maybe. Compliance might be higher there because they’ve just had the surgery that day so they’re all ears and want to learn how to get home safely and arriving safely. Whereas here they’ve potentially had that condition and that mindset for 10 or 20 years, and they’ve kind of muddled through even though they’ve not been happy.

## And so rooted in that sort of thought pattern?

### Yeah. You can’t just sort of say oh, you’re going to hear this once from me and your life’s going to turn around. So I think people will have tried and…

## They’ll have heard it all before.

### Yeah. So I think you’ve got to just, I don’t know, just a more collaborative approach. I think everyone’s doing it but maybe to a greater degree here. I haven’t worked in a hospital for a few years so – but when I did, I think I had these sorts of thoughts. If I knew that someone was lonely at home and they were a bit doddery after their hip I might say you can stay here another day. So I’m still having those thoughts. And I think as more and more of the biopsychosocial model is adopted, and thinking about working with patients in, like, a care plan type collaborative way, I think yeah, more and more physios are starting to think that way, or allied health.

## Do you think Health generally is moving in that direction?

### Yeah.

### Yeah, I definitely do.

## I guess you’ve probably outlined really what you think the role of the hospital is in terms of these clients.

### I do think about this sort of thing a lot.

## I can tell, you’ve given a lot of thought.

### I think up and down – you know, just because I’ve actually had funny experiences in my past. When I very first started I was really hungry to do a quality project and in the gym in the hospital there was a piece of equipment that was broken for 100 years and I said I’m going to fix that equipment. Because it was the cable that allowed everything to work, and they said oh, it’s been broken for so long, no‑one’s ever been able to fix it. And I just stood up to them and said I’m going to fix it.

### Anyway, I did fix it and everybody said oh my goodness, I can’t believe you fixed it. Then I paid the minimum price to the technician who fixed it and he said, you know what, that equipment’s only worth $20, it’s not even that safe to use. And I realised that sometimes you think you’re doing the right thing, it’s broken and I’ll fix it, but actually, did you need the equipment in the first place? Was the equipment actually worthy of fixing? Could there have been a better way to do it? So I just learnt – like, I just sort of had a funny moment when I just thought when people come in and see me for the knee, if we stick to the same examples…

## It’s like a metaphor.

### …and I’ll fix the knee. Am I really doing – you know, I’m going. I’ve moved your patella and I’ve freed that up and that’s less painful, but that person might go home to three children and are awaiting for a heart transplant. Am I really doing the right thing?

### So it’s like I have to just think a bit broader and think is fixing the knee – like, that’s what they’ve come in for, and that’s what they want and the patient does want that, but if I use that analogy, is that the best way to help that patient? We can still look at the knee because I don’t want to say, oh that’s nothing compared to all of the other things, but in the context of that person where does it fit in and what’s the bigger picture? So I think from having that experience, I don’t know why I refer that into my mind all the time, don’t fix the gym equipment when the whole gym equipment was not worth fixing. So I think that’s something that I don’t know, made a big impression.

## Very interesting. How then, as a leader do you instil that in your workforce?

### Honestly, it’s still quite new, but I’m learning, I would say, phase one. I wouldn’t say I did all the wrong things, I was just a super keen bean, wanted to tell everyone I’m here, how can I support you? What do you need? And everybody responding in kind, oh this way, this way, this way, this way, this way. And then we’re saying great, I’m on it, I’m on the case, just to let you know I’m still on the case everyone. But phase two, which I say I’m entering now, and who knows how many phases, is to say what is it about that – is it worth – you know, tell me a bit more about it, why do we need this thing resolved? How will it benefit you? How will it benefit patients? What are the steps that might be involved? So, just asking a bit more, a bit like the gym equipment, to say where does this fit in? How is it really helping us? Could we just – do we need to resolve it/not resolve it? Does it need changing/not changing? Let’s think a little bit more about it, and let’s work together. What could we do together? Could you start the ball rolling, or do you need to start the ball rolling, or pave the way for your team leader to facilitate you having time to do this, rather than just me doing it all. I know that sounds funny.

## Not really, it makes sense.

### So first things in my mind is how can I support people learning? That’s number one, and secondly, trying to model good behaviour, like having lunches, and self-caring. So not modelling I just work, work, work, work, work no matter what, so that everybody doesn’t feel oh, the way to get on with [Helwn] is flogging yourself, but instead wanting people to say no, we always take lunches, we take time out, we talk to each other. And you know, when someone gives me a job I’m thinking how can I support this person to learn? It doesn’t mean I’m handballing it back, I want to learn as well, so how can both of us learn? But how can I learn to be a better clinical leader? And how can they learn to have some skills?

## And in terms of that, what you’re saying, having lunches and talking to each other, could you just lastly, talk a little bit about what those relationships in the team - the value of having those relationships in the team, what does that do for care, and what that does do for clinicians?

### Yeah. I think obviously I’ve learnt this by doing it the wrong way. Initially I thought I’m just going to work so hard and I’m going to show everyone I’m the best clinical leader. I’m going to work through everything and [cross talking 0:29:00] but then, I think just, you know, having supervision and, you know, utilising resources on leadership. I think that’s just the wrong – sort of like a step one thing. [cross talking 0:29:15] but actually, now that I’m evolving, or developing some skill, I think that’s the wrong way. So, to come back to your question, in my phase two of trying to be supportive of good self care practices, I think that since I’ve been doing it, that the team are much more relaxed, much less resentful, or upset about – you know, there wasn’t any forced you must work through your lunch hour etc. There was just a feeling that, oh well, she’s doing a bit then I should do a bit. But it’s not fair, it’s not fair…

## It’s hard being a leader, isn’t it? It’s a tough gig.

### Yeah because you do want – I personally think I don’t mind, but it sends out the wrong message. And so even though I’d rather work half of my lunch hour, for example, than stay behind or ponder over it another time, at the same time it’s going to have a detrimental effect on everyone because everyone, just the creep of work, people will come in and then be resentful, and then I think the ramifications of that is I don’t feel that well today, I’m going to take a day off.

## Tha is impacts work?

### Yeah. And whereas I think if you just have these nice boundaries of let’s all stop and have lunch, let’s all – you know, if you need to leave five minutes early, that’s fine, don’t worry, you know, as long as it doesn’t become ridiculous, let’s just all show each other a little bit of kindness to each other and our self care, then actually people are quite willing to sort of say hey, I don’t mind on this one time helping out with that, or I don’t need that self care day. So it’s like the hare and the tortoise sort of mentality.

## Thank you. Thank you so much. Do you have any questions for me at all?

### No, just – does that sound [cross talking 0:31:31] the feedback you’re getting?

## All of the feedback’s very different, very very different. Some participants have gone completely down the road of, like, efficiency and effectiveness, and the best way to get the most out of the system. Others have talked about how they’re perceived by other colleagues in the organisation. And then yourself, you know, talking really about your – your leadership journey and what that’s like, and how you’re wanting to skill up your staff. I love the conversations you’re having with your patients and that, that really open – you know, it’s holistic, it’s very holistic and it’s dynamic as well, so you’re working with them with where they’re at, at that point in time.

### Yeah. Oh good.

### And I think everyone here in community health does it, so you know, we’re very proactive that way. So not just in [local area]. Like certainly amongst the physios and EPs we share that information and try to do that.

## I’m wondering, because your organisation kind of does reach out into the more sort of rural areas, you know, and I’ve worked in [here] locally when it first started and there was that real sense of, I don’t know, being quite not the busiest city hustle and bustle, having a more kind of countryfied, more kind of connected vibe to the community, do you think there’s something in that with your organisation and how you work with people?

### Potentially. I think potentially. Like, culturally it seems a bit friendlier from just anecdotal chatting to other therapists in other much more major health networks. So I think here’s quite friendlier. I know that’s a funny word.

Especially even more of it, like in [Town Name] it’s very family sort of focused.

## It’s a smaller environment, more connected to the community.

### And lots of people opt – lots of amazing clinicians opt to work in a seemingly quite removed and remote spot down in [Town Name] because it has got that nice family feel and so there’s a good balance of, you know, work and clinical skill upskilling, but also – what’s it like, staff sort of getting on less. I don’t know the word, I can’t think of the word, but there’s a much more collaborative feel.

## Is it more autonomous as well, do you think? Or is it just a different way of working?

### Yeah, just different. I think people have made quite – people who often stay long term down in [Town Name] or here have often made the change to move down to this area, so there’s a bit more of a work/life balance.

## Yeah, it’s a beautiful area.

### Yeah, so I think there’s that if you’ve made that work/life balance you’ve switched off, to some degree, that kind of climbing the ladder to the CEO type thought and you’re just happy to do really the best you can for the day and then go home and spend it with your family. I don’t know, that’s just my…

## And you live in the community that you work in.

### Correct. And the money goes into the community, so there is a bit more of a community feel. But I don’t know, that’s just my…

## Your take on it.

### Yeah.

## Well that’s what I’m asking,

### Yeah. So that’s just my, you know, anecdotal feel, and all my biases.

## Alright. Well I’d better let you get back – I’d better let you get back to your work.

### Alright, lovely.

## Thank you.

### 

[End of Transcript]