Title: I4\_24.02.2023

Interviewee/s: GP7

Interview Date: 24.02.2023

Interviewer: Q

Q: And on here. Oh, wait a second, I don't want to do it on that one. Okay, so that's recording now. So, just as a general introduction to the interview, would you be happy to just introduce yourself and say a little bit about what your profession is and what area of [place] that you work in?

GP7: Yeah, I'm [name], I'm a GP. I work in [place].

Q: Thank you. So as a researcher who does not work in primary care I'm not familiar with what happens in practice. It would help my understanding, first of all, if you could have a think back and give me an example of any time that a woman in the age group of thirty to thirty-nine years has presented to you with a concern about their breast cancer risk or about breast health, and, if that has happened before, just kind of talk through what happened during that interaction.

GP7: So it's quite a frequent presentation, I would say. So, obviously people present to us with lumps, which is slightly different, I guess, but we do have ladies who present to us, probably most commonly with family history, so are worried because, you know, maybe their mum's developed breast cancer or they might have a few different people in their family who have developed breast cancer, so they're worried about, you know, a genetic link and what their risk would be. So, you know, we talk about – you know, talk about that and, you know, do a bit of a family history. So, yeah, that's a, you know, reasonably frequent presentation, I would say.

Q: Hmm, mmm. And how do you feel having those interactions?

GP7: Um, I guess, you know, we have services that we can refer patients onto, so, you know, we've got a specific, you know, genetics service that counsels people around their sort of risk of family history – risk of breast cancer, and do, you know, an assessment of family history and, you know, further testing if needed. So I feel quite confident that I can refer patients to the right place if I feel that there is an increased risk.

Q: Hmm, mmm, okay, that's great, thank you. Okay, so breast cancer becomes more common in women in their thirties and it's currently the most common cause of death in women aged thirty-five to fifty. Before the age of fifty years, at least 65% of women who develop breast cancer do not have a family history, and this means that they're not currently identified as being at increased risk. So currently, there is no defined systematic mechanism to identify this group of women. The introduction of breast cancer risk assessment for women aged thirty to thirty-nine years would allow them to find out their risk of developing breast cancer in the future, and this would have the benefit of women who are identified as being at increased risk could then be offered earlier breast screening, as well as methods to reduce breast cancer risk. So I was wondering if you could tell me what your immediate thoughts and reactions are to offering women the opportunity to find out their breast cancer risk estimate from the age of thirty years.

GP7: Yeah, I think, you know, if the research really shows that, you know, they're – that you can increase – you can identify those ladies at increased risk – obviously I've had a – did read the information before you sent and, you know, there’s some quite generic stuff, isn't there, around, you know, weight and age and alcohol consumption and all that kind of thing. So you do – I can't remember all of the different elements, but I was kind of thinking that, you know, there's probably quite a lot of people who would end up falling into that category, actually. But if the evidence is that, you know, we can identify people at higher risk to then go on to have, you know, the investigations that are needed to potentially either identify breast cancer or put them into an earlier screening programme, then I would be supportive of that.

Q: Can you tell me a little bit more about what you mean when you say evidence?

GP7: Well, I guess, you know, just thinking about the criteria that you developed. So, you know, I think there would need to be some – you know, I would expect there to be some really good evidence that, you know, actually, we know that these things, you know, increase your risk of breast cancer cumulatively, we know it increases it by, you know, whatever amount that might be. And, you know, so I'd want to feel confident that there was that evidence behind the – you know, behind the data that you were using and, if that was the case, then, you know, I would feel really positive about wanting to, you know, speak to women about that and, you know, signpost, refer those ladies with the identified higher risk on for, you know, investigation or early screening.

Q: Hmm, mmm, okay. Can you think of any particular benefits or concerns that you'd have about introducing this service for this age group?

GP7: I think, so benefits are, you know, identifying breast cancer earlier. So, because we don't screen these ladies, you know, I think you worry that the breast cancer might be, when it is found, is found at a later stage, for example. So, you know, earlier diagnosis would be important. And, even if ladies didn't have breast cancer at the time, if they went into an earlier screening programme, then hopefully that you would, you know, detect cancer earlier as well, you know, for ladies who are kind of worried about that, you know, if they've got some family members, they might feel reassured if they're sort of, you know, being seen and identified and screened as well, so that would be a benefit as well. I suppose from a, you know, negative or a risk point of view, you know, there's maybe something around, you know – there's a reason that screening the general population, I guess, starts at fifty and not younger than that, so there's probably something around the pick-up rates, isn't there, and, you know, I don't know what the – you know, if there's – maybe there isn't so much around false positives, for example, or false negatives, I don't know, I've not really looked into it. But I suppose you –if you're referring people off into a screening programme, you do kind of worry about that, about people being sort of investigated unnecessarily, for example, so there's maybe something around that. I think there's something around GP workload as well, because obviously this would be something different to what we've done previously, so there'd need to be some education and training around it. And, you know, this is – you know, I would see this as a really positive step forward and hopefully it wouldn't just be with breast cancer, because as we get more information about different types of cancer, you know, we might be talking about breast cancer today, but in a few years time you might be talking about gastric cancer or, you know, whatever cancer it might be, and so, you know, potentially that could create a lot of extra work for general practice. So, you know, I think, we need to think about, you know, the additional resource that would be needed for GPs to be able to deliver these kinds of services.

Q: Yeah, okay, thank you. What are your immediate thoughts and reactions to primary care identifying and inviting women to a breast cancer risk assessment?

GP7: What are my – sorry, I missed the first bit.

Q: No, it's okay, what are your immediate thoughts and reactions to primary care identifying and inviting women to a breast cancer risk assessment?

GP7: Yeah, I think we're in a good position to do it, because, you know, we – you know, we know our patients really well. I think patients would feel confident about coming to see their GP to talk about these things and, you know, in terms of, you know, population health and detecting breast cancer earlier, you know, hopefully we'd have a real, you know, impact on that. I suppose, again, my worry would be, you know, how long the conversation would take, for example. So, in primary care we have, you know, ten minutes, which isn't very long, so, you know, depending on, you know, how the kind of counselling side of things and how in-depth it is and, you know, is ten minutes enough to do that, for example? You know, at the moment, as GPs do we have the knowledge and the skills to be able to do it? You know, I think we would need some additional training, and, again, it's around the resource as well, so this is something, you know, additional, it's extra, it's not something that we're doing at the moment. And, you know, it could be the start of lots of these different risk assessments for cancer, so I think we would need to look at the additional resource that would be needed for primary care to deliver these types of services.

Q: Could you tell me a little bit more about what kind of education or training that you would envisage – that would be needed?

[10:03]

GP7: So I suppose there's something around the kind of, you know, tool itself and how it works and, you know, how it kind of determines people's risk if there's some kind of score or percentage or, you know, whatever it is and what the evidence is behind that because obviously you'd want to be able to explain that to patients as well, why, you know, they've potentially been put into a higher risk category. And, you know, something around, you know, what that means for them. So, you know, how – I think discussing risk with patients is often quite a difficult thing, I think, no matter what risk you're talking about. It's – you know, sometimes you need to be able to put things into context for patients I think – because otherwise it sometimes feels a bit abstract. So, I think, you know, there'd need to be some sort of, you know, education and training around what that actually, you know, means for patients, you know, when you're sort of describing the risk. And I suppose, you know, depending on what happened next, so I think there was something around genetic testing, wasn't there, so something about sort of mammograms and the genetic testing. So I think we'd need to have more information about what that involved and what – you know, what in terms of genetic changes were being looked at and what that could potentially mean. And, yeah, and I suppose that's maybe something that as, you know, as GPs, you know, we're not really involved in sort of the genetic testing side of things, that would be quite a new thing for us, to be explaining that. And, you know, maybe it is something that would – you know, needs to be more high level than in-depth, but I think that is kind of an area of medicine that we're not really involved with that much.

Q: Okay, yeah, that's fair enough. What are your immediate thoughts and reactions to primary care involvement in breast cancer risk assessment and management? So maybe being a bit more involved then, like you currently are if a woman comes and you might do like a family history, how would you feel about being more involved in that?

GP7: I think if there was a tool, so, you know, in the information you sent, you mentioned it could be similar to a QRISK, so as long as you had all of the information, it would just ping a score out. So you wouldn't have to particularly calculate anything, which is really good. So, you know, I think from that perspective, you know, if something like that was – you know, we use EMIS, for example, so in our computer system, then obviously that would be, you know, really straightforward. So I think in order for GPs to be involved in something like this it would have to be something that was really quick and instant and not where you'd have to, you know, spend ages plugging lots of details into things and, you know, it taking ages to come out with a score. So, you know, from that perspective, you know, I think that would lend itself to being delivered by primary care.

Q: Hmm, mmm, okay. And how acceptable do you think it would be to have an increased role in breast cancer risk assessment and management if you were thinking about your colleagues or your own experience?

GP7: I think if there was education and training and resource attached to it, I think primary care – you know, I think it is something that primary care could look to deliver. So in primary care at the moment where, you know, we have – we're developing lots of additional roles that are associated with primary care, so we employ sort of mental health workers, physiotherapists, occupational therapists, pharmacists, you know, whether we could look at roles that had a focus on, you know, this kind of element, maybe. Not – it wouldn't just necessarily have to be restricted to breasts, but looking at cancer risk assessment. So, you know, whether there are people within the primary care team that you could train to, you know, do the risk assessment and have these conversations, so, you know, that's a potential, you know, from a resource and workforce perspective, whether we could look at it from that route. But, yeah, I think the main concern from colleagues would be – you know, would be around that resource, because, you know, you're – if you're looking at the, you know, the demographics, you know, we're saying – you know, you're saying everyone, aren't you, between the age of thirty and fifty, you know, to do this risk assessment on, that's a lot of people, and potentially a lot of people who are going to be coming back at higher risk depending on where you're – you know, you set your bar. So, I mean, that's a huge amount of extra work, isn't it, and just – you know, there's no capacity in general practice at the moment we’re, you know, we just spend our whole – you know, we spend a lot of time fire fighting and trying to do all the urgent stuff. And, you know, we've still got lots of our bread and butter, long-term condition stuff that we're – you know, we're trying to get back on top of after the pandemic. So I think to just put a huge amount of extra workload on us without any resource, you know, I think there would be a lot of push-back on that, you know, even if we felt it was the right thing to do. But if it was resourced properly, then, you know, I think general practice would want to be involved in this.

Q: Hmm, mmm, thank you. Okay, so as you've already mentioned, that risk of developing breast cancer is best calculated with a combination of like three different measures, so I'm just going to share the – oh, if I can find it, I've got that many windows open. Where's it gone?

GP7: It happens to me all the time, you’re trying to share your screen and it's like, oh, I've lost what I'm trying to share, always disappears.

Q: It's down here, I've got too many things open. I might have to look over here. Can you see that?

GP7: Yes.

Q: Okay, cool. Yeah, so it's just to talk through this diagram, so that you've got it there whilst we have a discussion, rather than just having to retain all the information. So, yeah, as I mentioned, the idea would be that it's almost like – well, it's a three pronged risk assessment, so there's three different components that would go into it. So the first would be a self-reported questionnaire, and this is really just women reporting on what – on factors that we know are associated with breast cancer risk. So this is kind of what you were saying before about your more like generic items, so height and weight, family history of breast and ovarian cancer, age at first period, age of first pregnancy, oral contraceptive history and alcohol consumption. And then the second important risk factor to assess in this age group is breast density, which would have to be obtained via a mammogram, and this would be looking at the proportion of non-fatty tissue compared to fatty tissue. So we know that women with a higher proportion of non-fatty tissue are at an increased risk of developing breast cancer so that's why that's important to measure. And the final part would involve a woman providing a saliva sample so that we could do a DNA analysis and not only would this look for your mutations in high risk genes such as like BRCA1 and BRCA2, but bearing in mind that that is going to be incredibly unlikely because these women don't have a family history. We'd also be looking at an output called a polygenic risk score, which is – there's a lot of common genetic changes, that on their own might not cause an increase in risk, but when they're put together, cumulatively they do increase risk. So there would be some women who would be identified as being at increased risk on the basis of that rather than the mutation, if that makes sense, but it would cover both just for it to be comprehensive. So that's an overview of the three components, so I was just wondering about, if we take the first one, self-reported questionnaire, is to ask you what do you think about primary care collecting information from women about this list of risk factors?

GP7: So I suppose, I mean, you know, a lot of stuff we collect anyway, don't we, so, you know, we normally have people's height and weight. When people register with us, you know, they include sort of family history as part of the registration. I guess age at first period probably isn't something that commonly collected and the age – I mean, you know, we normally – we should code pregnancy, maybe it doesn’t get coded systematically, so you might have to specifically ask that. Contraception history as well, alcohol consumption, we normally record that. So there are bits that we already record as part of someone's registration and, you know, when – and, you know, as part of that offer, you know, often we invite people in for their weight and height as well. So some of it is collected, some of it would have to specifically be asked by somebody.

[20:21]

Q: Hmm, mmm. And how do you think that that would be best done if we were trying to collect the other information?

GP7: I mean, it doesn't have to be a clinician, does it, you know, collecting that – the information. So, you know, you'd have to, um – I suppose there are different ways that we do it. So, I mean, we use a lot of text messaging in general practice, so, you know, you can send text messages out asking for information. I don't know what the hit rate for that is, I don't know how often – we do it a lot and often people don't respond, some people do, but, yeah, you might not get lots of people responding. I suppose maybe the downside to that is, it might be quite difficult to get across in a text message or a letter about the reasons for it, you know, unless you're actually sort of talking to someone who's really explaining, you know, this is why we're doing it, this is why it's so important. But it's one way of reaching a lot of people without using very much resource, I guess.

Q: Hmm, mmm.

GP7: But, yeah, I mean, obviously it wouldn't need to be a clinician to collect it.

Q: So who are you – if you could just explain who you'd mean in terms of who else could do it, if it didn't need to be a clinician.

GP7: I mean, you could have a member of admin staff, couldn't you, asking this. I suppose, you know, you can send questionnaires out and I suppose it's how you get the information back. I mean, we do send like questionnaires out through SMS and people just send them back, you know, send them back via email to the practice, so you could do that. It would still need someone to input the data, so it would still need – there would still be that resource needed to put the data into the clinical record, but an admin person could do that.

Q: Okay, yeah. Are there any other key issues or barriers that you think there would be to collecting this information, other than – obviously you've mentioned about people might not respond?

GP7: Yeah, I guess that's probably the main thing, isn't it, it's – you know, I don't know what the response rates would be. I suppose the – you know, the other thing about, you know, whether it's – it might not necessarily have to be a clinician, but, you know, if you had to – if an admin person had to ring thousands of – you know, thinking about the number of patients registered, ladies registered with your practice between the ages of thirty and fifty, I'm not sure how many that would be for my practice, but, you know, if you've got a big practice you're looking at hundreds of patients, aren't you. You know, that's a lot of time, someone's time, contacting people, getting the information, putting it in, you know, coding it, putting it into the clinical record. So it is – you know, it is going to take a lot of time to do this.

Q: Hmm, mmm, yeah. Just to clarify, that the age group is thirty to thirty-nine.

GP7: Oh, sorry, I was – yeah thirty to thirty-nine.

Q: No, it's okay. Like I say, it's still going to be like enough.

GP7: It's still going to be – you know, depending on how big your practice is, you're looking at hundreds, stroke, thousands of patients, aren't you, that are going to need contacting, so that's a lot of time it's going to take to do this.

Q: Yeah, yeah, of course. On the flipside, then, is there anything that you think would help to encourage women to engage with this?

GP7: I guess – I suppose it's having the information about why it's important and the – you know, the possible potential benefits to them of doing this, and understanding their risk and, you know, if there are – if you are higher risk, then you'd go on to have further assessments. So I suppose it's being – you know, being clear about that. And I guess the other thing is, you know, so weight and alcohol, for example, that is something that you can influence. So, as part of reaching out to patients, you know, you can provide that kind of education around, you know, being a healthy weight and, you know, reducing your alcohol intake and, you know, even if you're not high risk, the benefits that that would have, you know, in terms of future risk and just more generally in terms of, you know, being overweight and drinking too much alcohol, obviously increases the risk of not just cancers, but cardiovascular disease and lots of other things, doesn't it. So I guess there might be a bit of a – an opportunity to, you know, do some patient education around that as well.

Q: Hmm, mmm, yeah, great, thank you. Okay, so one model of how breast cancer assessment could work in primary care is the development of a risk assessment tool similar to QRISK, which I know you mentioned earlier. So, for example, scores for mammographic density and genetic risk could be fed into the tool and a risk score generated once someone in primary care has entered family history, hormonal and lifestyle factors. What do you think about primary care coordinating the process of breast cancer risk assessment in this way?

GP7: So it wouldn't be a case of the sort of self-report risk assessment would then determine whether somebody needs DNA analysis or breast density, it would all be done together and then right, right, okay, okay. Um, so the idea would be that every lady between the age of thirty and thirty-nine would have a mammogram and have a swab, okay. That’s a – I mean, that's a lot of extra mammograms that are going be needed as well, isn't it. So from that perspective you're looking at like, you know, thousands and thousands of extra mammograms. So that's going to take a huge amount of resource as well, isn't it, and I know in [place] there are – you know, for our current screening programme they're struggling to provide – you know, I think there is a – I suppose with like – with everything at the moment, because of Covid and waiting lists and things, you know, I think there is a pressure on mammograms at the moment, so you would have to massively increase that resource as well. I think – I mean, because it's such a lot of people, you know, it does – you do wonder if – whether, you know, this should be coordinated by primary care or, actually, whether this would be better off coordinated by the breast clinic or breast services, something like that. I mean, either way you'd need a lot more resource, wouldn't you, but, you know, just thinking about the huge amount of – like the volume of information and the number of, you know, consultations that, you know, it would lead to. I'm not – you know, I'm just trying to think whether – you know, whether you would need to set up some kind of pathway or different service altogether to manage all this stuff. You know, just kind of thinking about if – you know, if people like do their DNA analysis, which might come out as, you know, an increased risk, but then don't want to go to their mammogram, you know, you'd have to somehow chase all those patients up, wouldn't you and, you know, it's – you know, it sounds – it feels like, because of the volume of people we're talking about, you know, it's almost a service in itself.

GP7: Hmm, mmm, yeah, yeah. So how do you think – so would you say, it would compare to something like the breast screening or like cervical screening programmes? So I suppose it's just understanding from you what you think primary care's role would be in it, and it's obviously completely fine to say that you don't think we should be involved, that is completely fine.

GP7: Yeah, I think I'm just kind of thinking about the – you know, reflecting on the like, the sheer volume of patients that this is going to involve and, you know, the screening is not coordinated by us, is it. I mean, obviously cervical screening, you know, general practice invites ladies in for their cervical screening and, you know, we do that, but the service itself is coordinated outside of primary care and, you know, I think realistically I think this would have to go down the same route, you know, if we’re – we're talking about a lot of patients and, you know, two different – three different tests if you include the self-report as well. I just don't think that, you know, general practice would have the capacity to deliver something like this.

Q: Hmm, mmm, yeah, that's fine, thank you. How would you feel, then, potentially, about having more of a role in communicating the risk score and making a management plan in comparison to assessment? So, if like you think the assessment part of it should be coordinated maybe elsewhere, do you feel there's a role for primary care in communicating the risk score or making a management plan or –

[30:22]

GP7: I think there's probably more of a role for that, but you do wonder if – you know, if this was part of a separate service, if the assessments are being done in a different place, you know, would it make sense for the whole pathway to be provided by that particular service? You know, you'd then have – you know, develop experts who could talk to – you know, talk to ladies about their risk assessment and about the DNA analysis and the breast density and, you know, what that exactly means. So, rather than kind of splitting the pathway, having everything kind of done seamlessly within the same service, you know, I think – whether that would make more sense than, you know, leaving the GP to kind of go through the results with the patient. And, you know, like I said, I think, this is – you know, it's really positive, isn't it, that we're doing – you know, we're talking about this for breast cancer, and hopefully this is the start of multiple conversations around cancer risk. So, you know, it would completely overwhelm general practice if we ended up, you know, having to do this for all different types of cancer as well. So, you know, creating a more bespoke service that looks at – you know, looks at everything together rather than splitting it up, that might be a better route to go down.

Q: Why do you think that that would be a better idea, to have it all in one place?

GP7: I suppose, from a – you know, there's something about the governance, isn't there, and, you know, what happens to the results and whose responsibility it is to explain the results. If the Investigations are being requested by someone, you know, separate service and the results are then going back to them, it makes sense that it's their responsibility to then communicate those results to the patient. You know, from our perspective, you know, if you can't get hold of the patient, for example, you know, for whatever reason, that risk would be then falling back to general practice, wouldn't it and, you know, if you can't get hold – you know, it takes quite a bit of time to get hold of patients and, you know, especially for something like this, if we're talking about increased risk of cancer, obviously, you know, you wouldn’t want to miss patients and not give them that information and tell them about what it means. So, you know, I think, in terms of governance and risk it makes sense that, you know, the whole service is delivered together, you know, without splitting the – you know, explaining the results parts to general practice and leaving us with that element of risk.

Q: Yeah, thank you, thanks for explaining that. Okay, so something – yeah, so if we can try and imagine, obviously I've heard what you've said in terms of like maybe it would be better coordinated elsewhere. But the other questions are more around if you were to do it, how would you feel about doing this? So you've made your point, yeah, it's come across that you think it would be better organised, perhaps, elsewhere. But for the purpose of the questions, this is like kind of asking you more what – if you had to do it, what you would think about it. But you've really made – like you've explained that really well, so thank you.

GP7: That's alright, I know what you're saying, so yes, that’s fine.

Q: Yeah, so the output of the tool would also include recommendations for management of increased risk. So currently it's imagined that women identified as being at increased risk would be able to access earlier breast screening, from the age of forty. In addition to this, two strategies that have proven benefit in reducing breast cancer risk are maintaining a healthy weight through diet and exercise and limiting alcohol intake and taking risk reducing medication such as Tamoxifen. These risk management options would need to be discussed and offered to women identified at increased risk. What do you think about primary care providing lifestyle advice about reducing breast cancer risk?

GP7: So, yeah, you know, if we were to deliver this service, I think, you know, that's something that GPs would feel really comfortable doing because we do that all the time about, you know, multiple different things, whether it's, you know, weight or smoking, alcohol, you know, whatever it might be. So I think, from a kind of lifestyle perspective, you know, primary care does that all the time. So, you know, GPs do it, we have clinical colleagues who do it, you know, our nursing colleagues and – so it's not just us who does it, you know, whenever anyone within primary care comes into contact with a patient and we feel we can provide some lifestyle advice, we would always do that. So, yeah, I think we'd be pretty comfortable with that.

Q: Okay. Do you think there's anything different about providing lifestyle advice with respect to breast cancer risk, in comparison with other diseases?

GP7: Um…, I don't think so. Other – maybe other than – like I say, I think risk is quite a difficult thing to articulate to patients, because it – you know, unless you can give some context to it, it's often quite an abstract thing. And I suppose, you know, people have different levels of risk as well, don't they, what's an acceptable risk to one person might be absolutely not an acceptable risk to another person. So I think if we were able to describe it more in terms of, you know, numbers of people, so many out of a 100 and, you know, if we could put a bit of context around it rather than just giving it a percentage, for example, I think that – you know, I think that would really help.

Q: Hmm, mmm. What – are there any key difficulties or barriers to having conversations about lifestyle advice, do you think?

GP7: I think, I mean, sometimes it can be a bit of a delicate conversation when it comes to, you know, people who are overweight, I guess, but I think we're – you know, we're pretty skilled in having those conversations, to be honest. It’s such an important thing to counsel patients about because it has such a big impact, you know, not just on cancer risk, as we've said, but heart disease, diabetes, you know, lots of other things, and there are things that we can do in general practice to support patients. So, you know, there are different places that we can refer patients to or prescribe, so it's a really important information – conversation to have. And I think, with alcohol as well, you know, we're very skilled at asking people about alcohol consumption and counselling people about that, and, you know, depending on the response, there are services that we can refer people to around that as well. So I think as GPs we're pretty skilled in that, to be honest.

Q: Hmm, mmm, yeah, great, thank you. Okay, so the other management strategy would involve risk reducing medication. I was wondering if you could tell me a little bit about risk reducing medications that you might prescribe within primary care currently.

GP7: For –

Q: Just for any other – do you prescribe risk reducing medications for anything else.

GP7: Yeah, I mean, like statins – you know, do you mean like statins and things?

Q: Yeah.

GP7: Yeah, so we're – you know, we're – we obviously do risk assessments around, you know, cardiovascular disease and, you know, we've talked about similarities with QRISK, so, you know, in terms of that, you know, we prescribe a lot of statins, so yeah.

Q: And how do you feel about that? How do you feel about risk reducing medication as an option?

GP7: Yeah, I think, you know, it is – you know, absolutely, it's all about, you know, shared decision making, isn't it and, you know, we talk to patients about their risk and offer medications. You know, some people don't want to start medications, you know, they've got – they have particular reasons for not wanting to start it, so patients decline, and we're quite used to having those con – kinds of conversations with people. And, you know, there's often – it's often not just about medication, obviously, as we've discussed, there's often a lot of lifestyle things that people can do as well. So yeah, I think as GPs we're pretty confident about having those conversations as well.

Q: Hmm, mmm. So what do you think about primary care discussing and prescribing breast cancer risk reducing medication such as Tamoxifen?

[39:53]

GP7: So yeah, that's different, isn't it, you know, just in the sense of we don't prescribe Tamoxifen for anything currently, it's obviously a drug that's prescribed in secondary care. So, if GPs were going to prescribe that, we'd obviously need a fair bit of, you know, education and training around it, you know, thinking about the length of time that people – you know, how long do people stay on it for and, you know, the risks and benefits. Because, I guess, depending on how a service was set up, you know, it's unlikely that patients would come into contact with secondary care clinicians as part of this service. So, you know, it's unlikely that there'd be the option of a shared care agreement, for example, so it probably would come down to us, and obviously that's – you know, if GPs are prescribing this, then that's a big increase in workload as well, isn't it, potentially, depending on the numbers of patients that come back at high risk and that's recommended, you know, that's – you know, that would increase workload as well because there's the consultation. So, you know, you'd have to have that consultation with patients and the counselling, there's the ongoing prescribing, there's any monitoring that you might need to do alongside it. So yeah, I think there'd – I think there'd be quite a lot of workload implications associated with us prescribing Tamoxifen. I think it would – you know, we would need to think about the resource that's required for us to do that.

Q: Hmm, mmm. Are there any other difficulties that you think there would be to taking on a role in prescribing that?

GP7: Um, I suppose it probably is just around that, clinical responsibility, isn't it, you know, it's not – like I say, it's not – we prescribe – we take over prescribing from secondary care once someone's been started on Tamoxifen, but at the moment it's not something that we initiate. Yeah, so I guess there would – you know, like any new medication, there'd probably be a bit of, you know, maybe nervousness initially because it would be a new drug for us to prescribe. So I think there would need to be some, you know, support around the prescribing. And, yeah, I think the other pushback would be that it's – you know, it would cause quite a lot of additional work for GPs. I guess we've got – we do have our pharmacy colleagues that work with us. So, you know, we've got some really good pharmacists in my practice, for example, so I suppose it wouldn't just be about training up GPs but, you know, potentially training up our prescribing pharmacy colleagues as well.

Q: Okay, yeah, okay. Can you think of anything that would help you feel more confident discussing and prescribing, or anything else that would be beneficial to be able to take on that role?

GP7: I guess, there is some really good protocols that get developed. So we have – so [place], we have [name of Medicines Management Group], so that's our [name of Medicines Management Group]. So they're excellent, actually, and they produce a lot of really good guidelines around, you know, if there's new medications, for example. So they're the – it's a really good resource for, you know, looking at the risks and benefits and if there's any monitoring. So I think something like that would need – you know, for [place], something like that, would need to be developed. And I – you know, and we have – so [place], we have, you know, the governance around it, we've got different prescribing groups and things. So, you know, it would obviously have to go to the various different prescribing groups and, like, clinical oversight effectiveness groups. So it would need to be agreed at a kind of locality level that, you know, this is the right thing for us to do, you know, it's safe, the resource is there, you know, it's properly funded, you know, looking at all the risks and benefits. So there are stages that it would need to go through before we would be able to prescribe it in primary care.

Q: Okay, yeah, thank you. Can you tell me about the impact Covid-19 has had on your practice in general?

GP7: Yeah, I think – so I think, like all practices, you know, it transformed how we sort of communicate with the patients. So, you know, we sort of went from seeing patients face-to-face to then, you know, talking to people on the telephone first. We've got electronic forms that people sort of, you know, fill out in order to communicate with us about why, you know, they're – what their presenting complaint is and, you know, why they'd like to speak to a GP or another clinician within the service. So that kind of – the way that patients access primary care has – you know, has changed. We still see patients face-to-face, so, you know, we – you know, we speak to people on the phone who we feel need a telephone consultation, but there are people who quite obviously need to be seen face-to-face, so now, we just give them a face-to-face appointment. But, you know, previously it was pretty much all face-to-face, no telephone, so that's been a really big change. I think we’ve seen – you know, a lot of patients during the pandemic, you know, didn't come for their blood pressure checks, they didn't come for their cholesterol checks, you know, we've – so I think we're finding that, you know, people's blood pressure and lipids have increased because we've not been checking and adjusting medications. In terms of respiratory illnesses, we've not been able to do spirometry because it was felt to be an aerosol generating procedure, so we've got lots of patients that, you know, are going undiagnosed, you know, through spirometry and not being able to have their regular reviews. I think, from a mental health perspective, we've seen a huge increase in mental health presentations, so that's had a huge impact on our workload as well. So, you know, we're – there's quite a lot of – you know, in terms of long-term condition management, you know, there's still a backlog of people that we're trying to get through to try and optimise their long-term condition management. So it did have a huge impact on – well, not just my practice, on the whole of primary care.

Q: So what impact, if any, do you think Covid-19 has had on risk assessment and prevention in particular?

GP7: Um, so do you mean in terms of people coming in for like blood pressure checks and cholesterol or just like screening or –

Q: Yeah, just like – just whether you think that there's been – maybe because the first like – I think other people have been saying that kind of maybe some things to do with risk assessment and prevention were kind of at the bottom, they weren't prioritised, is what I mean, kind of what – like do you think there's been a long – well, I suppose you've said that if people haven't been coming in for the checks – but, yeah, I'm just thinking about whether there's been a long-lasting impact on primary care doing those kind of roles rather than just dealing with – you know, how you said before, like fire fighting.

GP7: Yeah, I see what you mean. I think patients, you know, certainly when Covid first hit, you know, were not coming to the surgery at all and, you know, obviously that's changed now. But, you know, I think – I was looking at some sort of screening data the other day, so, you know, just thinking about bowel screening and breast screening and cervical screening and, you know, since the pandemic in [place] there has been a reduction in uptake of the various different screening programmes. So I know there is – because some of it was paused – we were still doing smears, actually – but, you know, just thinking about patients, maybe, like you say, not prioritising it. You know, when you've got, you know, a pandemic going on and you can't go out and, you know, obviously people developing Covid, and long Covid as well, you know, there's lots of people with long Covid, other things take priority. And I think, you know, maybe there is something about us, you know, reiterating the importance of prevention and screening and, you know, reminding patients that this is – you know, it is such an important thing for people's health. So, and that's not just for primary care, I think that's for – you know, that's for healthcare in general, isn't it, to be promoting those things and, you know, we've maybe not been doing as much of that as we have done previously because, you know, we had a different focus as well.

[50:06]

Q: Yeah, thank you. Do you think there's a place for breast cancer risk assessment and management in your practice or in primary care?

GP7: I think, having sort of had the conversation and looking at what it entails, I think that – I think it would be really difficult to deliver in primary care just because of the sheer volume of patients. I think it would take, you know, a lot of resource to enable primary care to deliver that. I think, because of the sort of complexity of it and the different tests that are needed and the follow-up, I think it would require a – you know, a properly funded separate service to coordinate and – coordinate the investigations and follow patients up who were at higher risk.

Q: Finally, then, what other – are there any other issues that you think would be important to consider if we were setting up a pathway, if it was in or outside of primary care?

GP7: So I think that, you know, the awareness, isn't there of – you know, so patients really understand why it's being done. You know, there's – you know,[place], we have a lot of health inequalities, we've got a really diverse population, you know, we – in terms of our cancer outcomes and long-term condition outcomes, you know, we – because of our deprivation we don't compare well to other parts of the country. So I think we'd have to have a real think about health inequalities, wouldn't we, and how do we reach more marginalised groups, you know, groups where people don't have English as their first language. You know, we need to think about learning disabilities and – so I suppose that – you know, that would be a really big consideration if you were starting up any service. There's the, you know, the resource from a mammogram point of view, because there would be a lot of extra mammograms. I'm not sure about the genetic testing, whether there's plenty of resource within that kind of service. And from a questionnaire perspective, there's going to be someone needed to collect the data, isn't there and then it's pulling all of that together, so who's going to look at the results, contact the patient, do the counselling and prescribing as well? So, you know, if you were going to have a separate service to primary care, for example, you'd need to have prescribers within that service as well if you were going to go down the route of suggesting Tamoxifen, so, you know, it's potentially quite resource intensive.

Q: Yeah. Can you think of any other issues if we think specifically about the age range of the women, is there anything that springs to mind of what you think would need to be in place to engage this age, so thirty to thirty-nine?

GP7: Um, yeah, I guess – I suppose in terms of that, I don't know if there's anything specific around the age maybe. [Pause] I'm not sure about that. I know – I mean, when you look at kind of screening, younger women tend to present less often than older women. I suppose thirty to thirty-nine is maybe a bit in the middle, isn't it?

Q: Yeah.

GP7: I don’t – just kind of thinking about smears and things, I don't know, you know, how it – if that's a kind of age range where, you know, there's more people attending than other age ranges. I don't know if there's anything around kind of age-appropriate messages or – yeah, I'm not sure about age, actually.

Q: That's fine.

GP7: It's quite an interesting one [laughs].

Q: Yeah, I just mean in terms of this demographic, it's – you know, reaching this demographic and –

GP7: I mean, I suppose you've got like – you know, you're going to have – a lot of women are going to be working, aren't they, it's working age, a lot of, you know, women are going to have young children, potentially. So, you know, whether – you know, whether there's ways of reaching women, you know, through that – through those lenses, potentially.

Q: Yeah, okay, thank you. Thank you for your time, that's all the questions I had. Is there anything you thought you would talk about today which you haven't had a chance to say and you want to mention?

GP7: Um, I guess – so just thinking about your – just thinking about when we were talking about health inequalities, just thinking about the risk assessment, there wasn't anything about sort of ethnicity on there.

Q: Oh, yeah.

GP7: I was just wondering, is – I don't know if you'd know, but is there an association with ethnicity and breast cancer risk, or maybe not if it's not within that – if it's not within the list?

Q: No, yeah – so, no, you're right, there is – there's particularly a link with the Ashkenazi Jewish are at a more increased risk. So as part of – this work is informing a trial of breast cancer risk assessment that's due to open any day now in [place]. So we're actually going to recruit 750 women to come and do this risk assessment, to do the three things and as part of that project, one of the main aims is to determine the magnitude of mammographic density contribution to risk in this age group, but a big part of that is looking at differences in ethnicity. So we're hoping to recruit a diverse range of participants, because currently the breast cancer risk prediction models are – the algorithms are modelled primarily on Caucasian European populations. So down in [place] and [place] they're doing a lot of work to change the – adapt the algorithms so that they are better suited to different ethnicities because currently, yeah, there is an issue with that. But, yeah, so, no, it definitely is – like on the risk algorithm there is a question, like are you of Ashkenazi Jewish heritage.

GP7: Okay, okay, that's interesting.

Q: Yeah. Okay, yeah, so – and then finally, what was the most important that you think you've told me today?

GP7: Oh –

Q: You’ve said a lot of interesting stuff there.

GP7: I don’t know. I suppose – I think it's a really – you know, it's potentially a really positive step forward, isn't it, because I – you know, I have patients who are young, who develop breast cancer young and, you know, it's a – you know, that's obviously devastating, isn't it, and if there is a way of identifying people at higher risk and using mammograms and the genetic testing, you know, to look at that and identify those ladies and put them into earlier screening, and hopefully then, you know, pick up breast cancer earlier, I think, you know, that is a really, really positive thing. And I hope that, you know, it's the start of lots of these different, you know, sort of risk assessments. So, you know, it would be great if we could do this for all different types of cancer. You know, obviously this is – you know, it has – you know, this is women, so this has a really positive impact on our female population, so that's great as well. I think my – you know, my worry is about the resource for it and the workload, and obviously we've talked a lot about that, but, you know, I think that's a real consideration when you're looking at a big population of women about, you know, how it's safely resourced and delivered.

Q: Hmm, mmm, yeah, perfect. I'll stop the recorder now.

[END OF RECORDING – 00:58:51]