Title: I3\_22.02.2023

Interviewee/s: GP6

Interview Date: 22.02.2023

Interviewer: Q

Q: Okay, so the recording has begun now. So just as a means of introducing the interview, would you mind just introducing yourself and if you – and a little bit about what your profession is and what area of [place] you work in?

GP6: I'm [name], I'm a GP working in [place] as a GP for six years, roughly and I work in [place].

Q: Okay, thank you. Okay, 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 if, first of all, you could give me an example of when you've had a woman in this age group of thirty to thirty-nine years present with a concern about their breast cancer risk or about breast health, and talk through what happened, if you've got that experience.

GP6: So a patient on – with that concern will need a physical examination. So it depends on what the concern is, if it's pain, mainly and it's the first time and it's not been – lasted for a long time, then probably we can try some medications for that for a couple of weeks and see how this responds to the medication. If it is a concern regarding a lump or discharge, definitely we need a physical examination. If it's a phone call we will agree to arrange a day for a patient to come to the practice for a face-to-face assessment. If it's a face-to-face assessment then we'll do it at that time. If it's for arranging an appointment, it's usually – because of the potential concern or the potential implication of the diagnosis, it is usually soon appointment so it is squeezed in in the next few days. If it is a face-to-face appointment, it depends if it is a female doctor or a male doctor. Sometimes it’s needed to call a chaperone there and we will do the examination, then we [inaudible 0:02:33] the patient.

Q: Hmm-hmm. So how would you – how do you feel about those interactions, if you think about a woman presenting in this age range with a concern about breast health or risk?

GP6: Um…, you mean how do I feel in terms of …?

Q: Like your confidence in having that like – yeah, your confidence in having that interaction.

GP6: Yeah, I am confident in having the interaction, I feel that I have enough training and experience to do a proper assessment and to reassure the woman if possible. However, I – because of what it is, the possible diagnosis that is associated to that concern, it is always, for me, I’m always having a low threshold for doing a referral to secondary care for further tests.

Q: Yeah, okay, thank you. Okay, so moving on to the actual topic of today's interview, 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 they're not currently identified as being at increased risk. Currently there is no defined systematic mechanism to identify this group of women but the introduction of breast cancer risk assessment for women aged thirty to thirty-nine years would allow women to find out their risk of developing breast cancer in the future. 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 their breast cancer risk. And I was just wondering if you could tell me a little bit about 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.

GP6: Um, I think it might be helpful, actually, I think it's going to be a good initiative. It is – I mean, we are – as you're saying, we are seeing in the practice that breast cancer is coming earlier in life and the screening programme of NHS is still way above the average or the age of some of the women who are having the diagnosis of breast cancer. And there's not few patients that know that and they have come to my practice asking for a private referral, as well, to be seen, because they know that they do not qualify for NHS screening programme and they want to be checked. So I think it's going to be a good initiative, I would be happy and receptive of that. I'm not sure, it depends on what it's going to demand from primary care, I'm not sure what is going to be the impact on the service and if it's going to be doable or not, depending on what is it that we need to do and up to what – it is – if it's going to be done like the blood in your stool test that they are doing now, it's done centrally and the patients receive invitations at home, by post, in their homes directly, so that is very helpful. If we would be needing to contact the patients, there is always a difficulty that sometimes the patient cannot, or doesn't want to, or is not contactable or doesn't want to be contacted for that.

Q: Yeah, okay, so we'll come on to talk about potential different ways that primary care could be involved, because the purpose of this interview is to understand what – how you think it would be best implemented if it was. So yeah, we will come on to talk about potential models of how it could work and you'll be able to explain to me.

GP6: Yeah, yeah, sure.

Q: Yeah, which one you think would be most appropriate. But I was just wondering if we could just go back to you saying that you think it would be good initiative, could you tell me a little bit more about why you think that?

GP6: I think it can reduce concerns and consultations in general practice, especially for patients who have had a previous family contact with breast cancer or a family history of breast cancer. And it is – if – and for breast cancer in particular it is very clear that the – well, it's like that with every cancer, I guess, but it's one of those that we potentially can get or can diagnose soon or at early stage, that's going to make a big difference to the prognosis and treatment.

Q: Hmm-hmm, okay. Are there any concerns that you would have about offering women this opportunity from the age of thirty?

GP6: Um, I think probably it will need to be rolled out progressively, because if we offer that to everyone from the age of thirty, we're going to be inundated with questions or demand. So probably reducing the age of the screening process is going to be better. Um, I think it has to try to be as less – they need to involve a contact with a doctor that has to be very minimum. So it's just going to be a test or a programme or something that is not necessarily involving a doctor examination or a doctor to fill out a form to do that, because that's going to take time, a consultation and time from seeing another patient.

[10:05]

Q: Okay, so what are your immediate thoughts and reactions to primary care identifying and inviting women to a breast cancer risk assessment?

GP6: Sorry, I didn't hear, my thoughts …

Q: Yeah, your thoughts and reactions to primary care identifying and inviting women to a breast cancer risk assessment.

GP6: Yeah, I think it is good. I think we can certainly do that but probably in stages of age and maybe, as I said, if it is possible to try to, not to make this another consultation for GPs because it is very scarce, the number of appointments that we can offer nowadays.

Q: Yeah, yeah, of course. Okay, so what are your immediate thoughts and reactions to primary care being involved in breast cancer risk assessment and management? In terms of how acceptable do you think it would be for primary care to assume a greater role in this than they currently do?

GP6: Um, I – it depends on how or what is going to be needed to be done, actually. So as I said, if primary care can do it and there are some things that can be done that doesn't have to be done necessarily by a clinician so if it's just a result – linking a result of a test or a questionnaire of the patient to something and then just sending that screening referral, it's going to be doable. But it depends on what is going to be requested from us to do, I mean, if we have to see the patient and do our consultation about family history or risk factors, it's something that they can answer even online, so I don't see the necessity of that taking the time of a clinician.

Q: Okay, yeah, yeah, that makes sense. Yeah, so I'm just going to share a diagram with you, which basically answers that question that you've just asked, about what would it actually involve.

GP6: Hmm-hmm.

Q: Can you see that?

GP6: Yeah.

Q: Yeah, great. Yeah, so this is an overview of what the breast cancer risk assessment would entail. So we know that risk of developing breast cancer is best calculated with a combination of three different measures. So firstly, women would need to complete a self-reported questionnaire which would ask them questions about known breast cancer risk factors, which would include height and weight, family history of breast and ovarian cancer, age at first period, age of first pregnancy, oral contraceptive history and alcohol consumption. The second component would mean that a woman would have to attend for a mammogram in order for breast density to be assessed, because we know that women with a higher proportion of non-fatty tissue compared to fatty tissue are at an increased risk of developing breast cancer. And finally, we'd need to obtain a saliva sample from women to perform a DNA analysis and this would look for mutations in high risk genes such as BRCA1 and 2 but it’s unlikely that we'll find any of those because these are women without a family history. But the reason that we'll look at that as well is because of polygenic risk score. So there's – which is a combination of multiple common genetic changes, which we know on their own don't increase risk but when – cumulatively, when they're put together they can increase risk, so that's the reason why we'd look at that. So if we take the first component of the risk assessment questionnaire, it's just to ask you what you thought about primary care collecting information from women about that list of factors there.

GP6: I think it's something that – most of it we have in the records and some of them, not necessarily but we can – I think can be done, actually.

Q: And how do you think that would be best achieved?

GP6: Probably sending the request to the patient. I mean, we're using now one programme called Accurx, that asks to send messages to the mobile number of the patients and then they can reply to that and you can put that – any question there, with any option and they can certainly reply to that, through that. And that's going to minimise any time spending on – any spending of time of many people. Because it's just after we – I mean, it's going to be one administration team sending the request to a certain group of patients and they can be sent to several patients at the same time. So they don't have even to see patient per patient. And then afterwards, seeing the responses, they are going to be filing them on the notes for the patient and seeing the responses there.

Q: Okay, yeah. Would you foresee any difficulties or barriers to collecting this information?

GP6: Yeah, sometimes the patient doesn't want to receive anything from us. They do not want to respond anything. We are trying to collect some information now because it is now in one of our – one of our targets is that we have to have a high number of recording the ethnicity of our patients and we are struggling. Patients are not – apart from – I mean, most of them they have mobile numbers, it's very few of the patients who doesn't have mobile numbers but there are many that they receive the text message and they do not reply to that. It's just – I guess that is because you – I understand the patients, as well, I mean, you receive text messages from everyone nowadays about – and some of them can be scams, you know.

Q: Yeah.

GP6: But I think that one, that would be the main problem collecting this information, the patient not looking into that. No, but if there is a good advertising about, that this is being rolled out, then I think patients are going to be involved.

Q: Hmm-hmm, okay, thank you. I'll stop sharing that now. Okay, so that was just talking about the first component but if we think about the breast cancer assessment as a whole so including the three components. So one model of how it could work in primary care is the development of a risk assessment tool similar to QRISK, 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 that we've just discussed. What do you think about primary care coordinating the process of breast cancer risk assessment in this way?

GP6: Um, I think that can be achieved, that’s something that we can certainly do. But I – it will depend on patient contacts because we do not review every patient systematically if they – usually, if they do not contact us or if they do not have any particular past medical history that we need to review for some reason. I mean, the group between thirty to thirty-nine years old, they are, in general, patients who are not taking any medication at all. Only the patients who are on some contraceptive pill or some contraception, we will be needing to review them at least once a year. But some patients are going to be using the coil or some sort of long-acting contraception device and they are not going to be consulting with us in the surgery. They should be but again, this is a group that we – that I feel like it is very difficult for us to be successful in getting engaged with a follow-up. There are many, many patients that even if you send messages when they are requesting their three monthly contraception prescription, you tell the patient they need an appointment review, that we need to discuss, you send messages to them, they don't do it for several months, even more than six months overdue and they don't come.

[0:21:17]

Q: Okay. What do you think could be done to encourage that group to engage in like a breast cancer risk assessment initiative?

GP6: I think advertising, I think advertising is good. I mean, and the fact that it is non-invasive test is going to be even better because it's like the stool sample it is much probable that patients do that rather than, for example, having a smear test. Because the smear test, they find it uncomfortable, invasive, many patients don't want that. Still, for breast cancer I think it's going to be probably easier and more accepted. I do believe everything depends on how well advertised this is and how it's sold to the patient, actually.

Q: How do you think it could be advertised?

GP6: Um…, I feel the most powerful way to advertise something nowadays is online, either in the social media, in YouTube videos etcetera. Television and radio, I don't feel like it is as used nowadays as your mobile phone. So it's – especially if we are trying to – if we’re aiming to that age group, I think probably social media. If we are aiming to that age group, I mean, we should be aiming to advertise from twenty, twenty-five years old so they know about that before.

Q: Yeah, okay, thank you. So how would you feel about actually communicating the –

GP6: It can be events as well. Now that I'm thinking about that, it can be events, like, for example, in a sporting event or in a concert, they can have like big canvasses or things that they're saying, that if you are thirty years old, you can have an assessment for that. Concerts, I don't know, any event.

Q: Okay, yeah, thank you. So how would you feel about actually communicating the risk results and making a management plan with a patient?

GP6: I will need to know exactly what is going to be the plan. I guess that that is going to be decided by NICE guidelines, though I'm not aware of any NICE guidelines for that group age or at risk group so what they're going to do, I'm not aware of those. But I think if it is clear what has to be done, for example, repeat mammography in so many years or repeat the test or a patient to have Letrozole or if a patient needs some referral for a follow-up in the clinic, then, yeah.

Q: Is there anything else that you think would be required to be able to communicate the risk result beyond guidelines?

GP6: Um, no, we will need probably a – well, if it's positive I would – or if it's a high risk, I would say we will need a face-to-face consultation with the patient, this is going to be better that way, breaking some bad news. But if it is negative or low risk, I think we can just send a letter to the patient stating what has happened, or a message to their mobile number.

Q: So who would you envisage actually communicating that risk score, then, who would take on that role at your practice?

GP6: Well, if we are doing the – if we are taking the samples and we are taking all the information from the records, then I guess we should do it. But the – I do not think that it is going to be a big work for a clinician, I see that as more as an administrative role.

Q: Okay.

GP6: So they know if it is the reasoning – the results come to you and you do the assessment, probably but then you can just send – okay, this patient, it's a low risk and just send a message to them.

Q: Okay. Can you foresee any difficulties or barriers with actually communicating the risk result to a patient?

GP6: Um…, apart from the fact that, again, the patient might not receive the result or take into account result, I think sometimes there has been some mistakes or errors with the pathology lab and the samples sent, not infrequent, unfortunately. However, to be fair, the lab acknowledges them and they know what has been the error and they are open to repeat and to support the patient repeating the sample if that is the case. There can be a bit of delay processing the sample depending on backlog, there can be a bit of delay if they are going to have a mammogram, there can be a bit of delay on that.

Q: Yeah, hmm-hmm, okay. So if we think about it as a whole, so obviously we spoke about the actual risk assessment process being those three components and then followed by the risk needing to be managed, are there particular aspects of that process that you’d feel more or less comfortable with having involvement in?

GP6: Um…, I think organising the mammogram would be the more time consuming, more problematic.

Q: Okay.

GP6: The other ones are a kind of simple the patient can just drop the sample and is going to be sent to the lab. The other ones are just taking information and sending it as well or putting it into the records. And then using the three of them, that would be a bit complicated as well, I mean, how do you know, if a mammogram comes, that the patient has completed the saliva or not, or if not, you have to chase the patient again. So that is going to – that would take a bit of time, actually, that would take a bit of time, it is a couple of minutes probably, checking the record of the patient and sending a message or sending a [inaudible 0:30:31]. If you are having, it depends, ten patients like that or fifteen patients like that, it's half an hour of your time already.

[0:30:39]

Q: Yes, yes, of course. Could you tell me a little bit more about why you said that the mammogram would be problematic?

GP6: Usually it's about bureaucracy, because for everything that we have to send to – I'm not sure if it's different in other parts but for everything that we have to request there is a form, there is a pro-forma for everything and you have to fill lots of boxes or tick boxes and it is a bit off-putting, I have to say. Because there is a pro-forma for everything, I mean, every single referral or thing that you have to has a different pro-forma. So it's a nightmare, actually.

Q: It sounds it.

GP6: The admin burden that we have to deal with every day in GP practices is a nightmare.

Q: So how do you think we could reduce the admin burden if this was to be introduced?

GP6: Um…, trying to make it simple. I'm not sure if – I mean, if it is going to be possible to do a direct referral to the services or if the patient’s going to be able to do that themselves, that would be – a self-referral, that would be very helpful, actually.

Q: So I'm just trying to understand how you would – how do you think it would be best organised if we compared it to – obviously this isn’t a screening programme it would be a risk assessment programme. But if we compared it to existing screening programmes and primary care's involvement in them, yeah, like how do you think this would be best implemented?

GP6: Hmm. Um…, I think the patient does the sample themselves for – stool sample, for looking for blood and that is very helpful. I mean, we receive the result but if they are positive they are already seeing them, so they are already being actioned centrally. For a smear test, they have to come to the practice and take them – and we take the sample but the results, again, go direct to the patient. So, and those are just – they are sent with a normal request form of a lab, of a laboratory test. So I do not think there is going to be such an easy process for requesting a mammogram. So that would be the main issue, trying to create something that it is easy to fill or easy to – or if the patient can just call a number and do the booking themselves, like booking appointment with the dentist, obviously they will need to be kind of a central thing, so they know that the patient is still the mammogram and not – or has had it recently.

Q: So where do you think primary care would be best involved throughout the whole process, if at all? I'm just trying to understand what you think primary care's role could be in supporting this.

GP6: We have the weight of the patient so that's the most important part on this equation, I think, the demographics of the patient. Not only the demographics but if they drink alcohol or not if they have been taking contraceptives or not. Um…, I think we will need to be involved because of that. That information, we – the GP surgeries, they have that and that's [inaudible 0:36:21] information for this.

Q: Yeah, yeah. So do you think that would be the extent of primary care involvement, or if we thought about what I was saying before, about actually communicating the result and maybe devising like a management plan, is that appropriate for primary care or do you think it should be done somewhere else?

GP6: I think that's going to be okay for being done in primary care. I think that's something that we will need to have conversation with the patient. We will just need a bit of guidance about agreement of what is going to be done.

Q: Hmm-hmm, yeah. So what professional group at your practice would you expect to have that risk consultation with a patient?

GP6: You mean with the results?

Q: Yes, yeah.

GP6: It has to be a GP.

Q: Why do you say that?

GP6: I mean, in my practice I do not have any advanced nurse practitioner or anyone, I have nurses and I think we will need to explain to the patient what are the next steps coming, what this might mean. Usually, with this – with cancer things and results and risks it is a statistic and the patients, most of the times they do not understand them. So it is going to be very important for the person who's going to break those news to have an understanding, to explain to the patient – to answer to the patient queries or concerns.

Q: Okay, so as we spoke about management, the output of a risk assessment would obviously include recommendations for how to manage 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 medications such as Tamoxifen. And both of 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?

GP6: Um, yeah, we have that discussion very frequently with the patients, actually, about things that put you at risk of several diseases and they – in general they do not differ too much, they are mainly like obesity, alcohol and smoking, or everything. So yeah, I think we are in a good position to have that discussion and we – I mean, particularly, we – I think all of us are taking the approach of every contact counts, so we try to do that every contact with the patient. I think, yes, we should be doing that and we should continue doing that.

[40:32]

Q: So if we think about who again in terms of what professions would be able to have that conversation, is that any different to the –

GP6: No, our nurses have that as well. When they are having a review of the patients with chronic conditions, they have the conversation with the patient about that as well. Um…, the problem that I see is that we're talking about such that might happen. So it's not like when you are having already high cholesterol or already hypertension and that is because you gained 10kg in the last year. And we tell the patient, well, you have to lose these kilograms or we need to give you some other tablet or some other medication or you are more at risk of having a heart attack. So the problem that I see with these things is that they do not cause any symptoms because they do not exist now and the patient is not going to have it.

Q: Right, yeah.

GP6: So that's the difficulty on having that conversation. But I – we have that conversation all the time with the patients, yeah.

Q: Okay, are there any key issues or barriers that – for having that conversation about lifestyle advice?

GP6: Um…, I think probably the most important barrier is the agenda of the patient if they have their own agenda and they want to talk to you about something else or they are expecting you to talk about something else.

Q: Okay.

GP6: When – apart from that is the time, because the appointments are not in excess and if you are seeing the patient for some reason, you can tell them, oh, you know that you have to stop the smoking or, are you still smoking? Have you considered reducing? When do you plan to reduce? Do you know we have here the smoking cessation advice, the smoking cessation clinic, I can do a referral for you. But you cannot go too deep into that because that's going to take several minutes of your consultation and you are consulting for something else. So you take the chance to try to help with that bit or to try to mention that. So you raise – you highlight this to the patient, so they know that this is still not good that they are still smoking or drinking alcohol or gaining weight but you cannot really explore what is happening.

Q: Okay, yeah, thank you. So the other management strategy would be to prescribe risk reducing medication such as Tamoxifen, I was wondering if you could tell me a little bit about risk reducing medications that you currently prescribe within primary care.

GP6: For breast cancer?

Q: No, for other – for anything else that you currently do, that you've mentioned about cholesterol, would you prescribe –

GP6: Yeah, well, we prescribe statins, we prescribe – well the smoking cessation clinic prescribe some medication to try to support that. It can be [inaudible 0:44:51] or it can be patches of nicotine in the process of reducing their smoking. We do not do anything with alcohol because that's mainly for the alcohol services and the patient has to get engaged with them. Um, we do – I mean, it's not a prescription but we do our referral to weight management services as well for patients who are at risk of developing diabetes or who are overweight. And trying to prevent, as well, in terms of musculoskeletal problems, we do prescriptions or we send referrals to the physiotherapy service as well.

Q: Okay, yeah, okay. So if you compared to other risk reducing medications that you currently prescribe, what do you think about primary care discussing and prescribing breast cancer risk reducing medications such as Tamoxifen?

GP6: I – personally I don't have any problems with that, I think it's going to be okay. I think it is going to be accepted by patients. I don't foresee any big problem with that, actually.

Q: Is that something that you've had experience of doing or not?

GP6: Not starting with, it always is started by a specialist but once the patient is on that we continue the prescription and once the patient has reached a certain amount of years on that medication, we have the discussion with the patient. And usually she's still – or the patient, sorry, the patient, she is still under the care of the specialist or they know because they have been instructed how long for they are supposed to take the medication.

Q: So how would you feel about actually initiating that prescription?

GP6: I would be okay with that; it depends on the guidance that I receive.

Q: Right, okay, yeah.

GP6: But if there is clear indication and clear guidance about that, then, yeah, I do not think – I wouldn't be opposed to that.

Q: Is there anything else in addition to guidance that you think you would need to become confident in initiating that prescription?

GP6: Well, if this is going to happen, probably some training, apart from the guidance – some training, some extra training for GPs, because it's very different to just read the guidance and to have the appropriate session with the specialist and you can ask your questions there. I think that's going to be very helpful, actually.

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

GP6: It has destroyed all the morale.

Q: Oh yeah.

GP6: Because it has made the job very difficult to do. It has put a lot of pressure in everyone, not only clinical team but admin and reception as well.

Q: Yeah.

GP6: There has been a bit of cross communications or misinformation, I'm not really sure how to word that but, between the doctors, the NHS service, the expectation of the public and the politicians and the waiting lists and all that stuff, and we are in the middle of all that. So it – there is a lot of unhappiness in patients that is transmitted to all the team in the practice. We have had many staff – several members of staff leaving, it has been very difficult to recruit. The pressure it is – there has been a lot of backlog and there is still a lot of backlog in work with regards to things that are needed from the hospital. Yeah, I think it has made things very, very difficult, not Covid itself but all the other things that came with that or after that.

[0:50:28]

Q: Yeah, that sounds really difficult. What impact, if any, do you think Covid-19 has had on risk assessment and prevention in particular?

GP6: I think a big impact because we had to prioritise other things and we had to prioritise acute illnesses and the care of – apart from the fact that it was mainly – for a period of time it was mainly remote consultations. So we are now trying to see or trying to catch up with patients who haven't had some blood tests for a while or had good control of some risk factors like hypertension and diabetes. So it is – yeah, it has definitely impacted and – yeah.

Q: Do you think it might have a longer lasting impact on conducting like risk assessment and prevention activities in primary care or –

GP6: Yeah, I think so, I think it can – it is something that is lingering there and it is very difficult to recover from it. We are still not in a good position.

Q: Yeah.

GP6: We're getting better but it is still not in a good position – the difficulties recruiting has put – I mean, there are more and more staff that they do not want to work full-time, so you have to kind of – you need to hire one people, you need to hire two or three for the same job.

Q: Okay, yeah.

GP6: So it always complicates things with working like that.

Q: Yeah. Do you think there is a place for breast cancer risk assessment and management in your practice currently or in the future?

GP6: I think so. It depends on what actually we will be needing to do as a practice and how much work that is going to mean for us but yeah, I think it does not sound a bad idea. It does not sound – like not helpful. It does sound like it's going to be helpful and really important actually, especially for a particular group of patients.

Q: So do you think it should be primary care's responsibility in terms of having that greater involvement in breast cancer risk assessment and management, do you think that's appropriate?

GP6: I do, yes, yes.

Q: What makes you say that?

GP6: As I said, we have most of the data of the patient and we do screening for – or we deal with screening for other conditions as well. I think probably we are in a better position to do that than others. I mean, the other – if we are not doing that, I don't see who is going to be able to. I mean, probably, if you or – well, someone commissioned particular clinics or surgeries where the patient can walk in, give all your details, have the mammogram and leave your saliva sample there all in one go. And then they themselves do that but that's going to be one particular clinic for doing one particular job and nothing else. I'm not sure if that's going to be financially possible.

Q: Yeah, okay. So finally then, are there any other issues that you can think of that you think would be important to consider when setting up a pathway for breast cancer risk assessment and management activities for women aged thirty to thirty-nine years in primary care?

GP6: [Pause] No, I think the most important thing is going to be to have proper advertising. The other important thing would be to have clear guidance about what is expected from us to do or how this patient's going to follow or what is going to happen with the patient after some [inaudible 0:56:40] a year.

Q: Okay, so thank you for your time today, I really appreciate your honest insights into that, so thank you for sharing. Is there anything you thought you would talk about today which you haven't had a chance to say and you want to mention?

GP6: Um, no, no, no, thank you. It was – I've never been asked about the impact of Covid in our practice and what is happening there, apart from my appraisal and wellbeing part of my annual appraisal. Yeah, it's always a part that looks like it is forgotten and they – everyone feels like things are just as usual, they are not.

Q: Okay, yeah, that sounds really tough to deal with. So yeah, I was really sad to hear that.

GP6: Yeah, that's what I mean by, we need to see, actually, what is going to be required from us, because I have spoken with other colleagues from other practices and it seems like everyone is just struggling at the moment, sadly.

Q: Yeah, no, so that will be a really important consideration moving forward so thank you for raising it. Okay, yeah, so that's everything. So I'll stop the recordings now.

[END OF RECORDING – 0:58:20]