Title: I7\_10.03.2023

Interviewee/s: GP9

Interview Date: 10.03.2023

Interviewer: Q

Q: Okay, so that's recording now. So just to introduce the interview then, please could you just tell me what your profession is and what area of [place] you currently work in?

GP9: So I'm a GP and I work in central [place] and a little bit further out in [place] as well, yeah.

Q: Okay, great. 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 you could give me an example, if you've experienced this, 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 kind of what happened and what you did in that interaction.

GP9: I'm sure I probably have seen someone like this, I haven't got an immediate example to hand, necessarily.

Q: That's okay.

GP9: But my feeling is I probably have seen individuals like this and I think it was an area of difficulty in a sense, perhaps because I'm a relatively newly qualified GP, not knowing exactly what I should be doing.

Q: Okay.

GP9: So I think my understanding was that, you know, certain criteria, if they're met, you know, if they meet certain risk factors, if the family history is strong enough, we can then forward them to screening earlier. But if they're not, then really my understanding was that we just sort of – you know, general advice as to what to watch out for, continued sort of surveillance from their point of view and then just advice as to trying to reduce their risk factors some of which, I suppose, you know, you're trying to identify in the study, yeah.

Q: So you mentioned there that you potentially find those interactions difficult. Could you explain a little bit more about, like, how you feel having those conversations in terms of like your confidence or –

GP9: Yeah, I think, like any of these things, it's difficult because general practice, in particular, is just full of uncertainty. So a lot of the time you've got, you know, women, quite rightfully, coming to you saying, you know, I'm worried about the risk of breast cancer, or any other disease and you have to kind of both tell them to kind of – you don't want to over reassure because there is always a chance, isn't there, you know, statistics say that there is always a chance. But then you can't raise the sort of worry level too high because ultimately, you don't want that to happen, either. So yeah, it's trying to strike a balance, I guess, and sort of looking at, you know, trying to work out if they're at genuine risk, high risk in that sense and, if we're really worried, we can – and they meet the criteria, we can put them forward to screening early. But otherwise, we are a bit limited and that can produce some anxiety but then, I guess the job in essence, is kind of full of all that already, so –

Q: Okay.

GP9: Yeah, so I'm kind of used to it, in a sense.

Q: Okay, thank you. Okay – go on.

GP9: Oh, sorry, no, no, go for it.

Q: 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. So 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. 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 women to find out their risk of developing breast cancer in the future.

GP9: Yeah.

Q: Women identified as being at increased risk could then be offered earlier breast screening as well as methods to reduce their breast cancer risk. What are your immediate thoughts and reactions to offering women the opportunity to find out their breast cancer risk estimate from the age of thirty years?

GP9: Yeah, I mean, in principle it sounds good, doesn't it, it does sound good. I guess you'd want the tool to be validated and to feel that you have confidence in it and that we're not just putting more pressure on the sort of healthcare system when we might not have the resources at the moment to fund it. But in essence, like, I think it sounds like a good idea, I don't have any sort of issues with it. It's just whether, yeah, you can have confidence, I don't know what sort of size of study you'd end up looking at doing to try and put like a control group against the group in the – I'm sure you've got plans further down the line, maybe, to do that but, yeah, I think if that was in place, I think that would be great, yeah.

Q: And why was your immediate reaction to say that it was good? What kind of benefits do you think it would have?

GP9: Well, if we're obviously missing breast cancers aren't we and, you know, anything we can do – if you've got that statistic and that's true, that breast cancer's the highest cancer, or just general sort of cause of death in that age group then I think we should be trying to do something about it, so if we can. And I'm sure even if it's not perfect and we'll probably talk about the downsides of it, maybe, as well but –

Q: Yeah, yeah.

GP9: I think – yeah, I think in principle, if it works well it could be a good thing, yeah.

Q: So what kind of benefits do you think it would have for the women?

GP9: So I think there'd be a sense of reassurance as well. I think there's a lot more awareness around breast cancer and there probably is a sense that when people get to thirty, that they're perhaps moving into a zone where maybe even some of their friends have had breast cancer. I know – not sort of directly someone I know now but one of my medical school cohort got breast cancer just before they were thirty, so would have probably been picked up maybe by this study, potentially. I think it was on the cusp of thirty. But yeah, you're getting into an age where a lot of people would know people who've had this and increase in anxiety, so it might quell that. And then – yeah, I'm trying to think of any other benefits beyond it just – if we're catching breast cancer, then it's clearly a good thing. I mean, it might in some senses increase uptake of other screening services. So if sort of a younger cohort is used to being screened, they might look more positively at, you know, the cervical or the – you know, the bowel screening programmes once they reach age for that as well. So I guess that could be another positive, yeah.

Q: Okay, yeah. And what do you think could be some potential harms or downsides of offering this to women?

GP9: I mean, it could increase anxiety [laughs] at the same time, you know, like if you're introducing this tool and you're making people think about every aspect of their health, you know, where – I guess there is a line to draw, maybe, in terms of just letting people live their lives maybe, I don't know. There's obviously the, as with any screening programme that it's never going to be 100% by any means, so you're going to get your false – what is it, your false positives, isn't it, false negatives. But basically, the ones that you shouldn't have –

Q: Yeah.

GP9: They've kind of gone on further than they should have done and they’ve had further investigations, potentially biopsies and, if it's not an aggressive form, you know, if you catch them earlier on towards the latter end of that period you're proposing, maybe they wouldn't have had any problems, anyway. It's difficult to say, yeah.

Q: Okay, thank you. So what are your immediate thoughts and reactions to primary care actually identifying and inviting women to a breast cancer risk assessment?

GP9: It's more work [laughs], more work. I think it's – like with all these things, I think there is a bit of a creep in terms of secondary care into primary care, potentially. I don't know whether you've spoken to other GPs about this and they kind of feel like they're working super hard already and it's great to be able to propose it but I guess it's another thing we'd have to kind of take on board. And I think, as with like what I said earlier, in principle it's great but I think you might need an expansion of GPs and change of Government maybe, I don't know. Not to get too political but, you know, I think it will have to be funded and not just on a shoestring and just given to GPs to just sort out and this is yet another thing for GPs to try and manage on top of what they're already doing. Without wanting to sound too negative, yeah.

[0:10:08]

Q: Yeah, that’s fine. So you mentioned there about potentially things creeping in from secondary care, do you think then that involvement in breast cancer risk assessment and management should be part of primary care's responsibility?

GP9: Yeah, I think so, in terms of – it's such – it's really blurred lines, it's so difficult because you could argue across the board for any condition, you know, shouldn’t GP be screening for that? But I guess breast cancer does have this, you know – it's high mortality amongst an age group that – we'd be hoping to catch it in – yeah. So I'm not – what was the question again, sorry? I’ve lost it.

Q: It’s okay. Whether you think it should be primary care's responsibility, like should it –

GP9: Should it be primary care, yeah. Um, I mean, I guess a lot of the things, having read through the tool and the things you'd be expecting, they're relatively easy to compile, aren't they, you know, this is – you could get pretty much all of it from a questionnaire. So it may be something that could just be – if you’ve got a computer system in EMIS for example that just calculated it automatically, it doesn't feel like it would be a real burden to be taking on necessarily. And if that then – I think it would be the next step, when I was reading about – then primary care would have to then talk about counselling the woman about, these are the things to – and feeding in the mammogram results and I think that's where it starts to become, you know, shouldn't there be a separate breast service doing this? So if they reach a certain threshold, yeah. But that's – in an ideal world, yes, we'd have clinics available to anyone who hits a certain percentage, just – and it – I guess we're so used to dealing with things like QRISK, where we're doing that as part of our daily service. But I think it would take some bedding in, something like this and education from the GP's point of view as well as to what we need to do, yeah.

Q: Yeah, so we'll come on to talk about –

GP9: Was that clear?

Q: Yeah, yeah.

GP9: It's probably not great [laughs]

Q: No, no. So you touched on a few things that I'm going to ask about later on, so we'll come back to things about like the way it – the best way it should be organised, whether it should be like a separate like who it should be affiliated with, almost.

GP9: Yeah.

Q: So yeah, so essentially then, like, how acceptable do you think it would be to yourself and if you think about your colleagues as well in primary care – how acceptable do you think it would be to be more involved in breast cancer risk assessment and management than you currently are?

GP9: I think it's a little bit difficult because I'm a locum GP so I'm – you might get a more sort of accurate response if you spoke to a partner who was having to balance budgets and, I guess there'd need to be, from their point of view, incentives to do that as well. But I think it's a good thing, I think generally it's a good thing but it's just whether it would be achievable with the resources we’ve got at the moment. You know, rightly, people complain about getting to see their GP and we've got yet another cohort of patients that are being put towards their GP. And the people already waiting to see a GP aren't going to – but that's more of a general resource issue, isn't it. I think if you resource the primary care better, fund it better, I think most GPs would have no problem, yeah.

Q: Okay. What else, except for resources, then, do you think would impact on how acceptable this would be to implement?

GP9: I think education, initially. You want to – if we identify women who are at high risk, we want to feel confident that we can tell them exactly what's going to reduce their risk. So, and I'm sure there'd be training programmes if it was to be introduced, you know, down the line. So yeah, I think that would be – I can't think of many other down points, really. I'd be really interested to – I bet the kind of group ones are really interesting, because I think you kind of – you hear other people's opinions don’t you and you think, oh, okay, yeah. When you're kind of left to your own devices it's a bit difficult. I can't think of any other down points from that point of view, maybe, yeah.

Q: Okay, that's fine. So more – if we delve more specifically into when you mentioned education and training, what in particular would you feel that you needed more education about?

GP9: I mean, how to use the tool, number one. So at what percentage are we saying this is an arbitrary cut-off, that these people – that these women need more input and we need to intensify counselling with them. And I think – was the – was the sort of – at that point you'd be also referring into screening earlier, is that right?

Q: Yeah, that can be a potential –

GP9: Was that the intention, it's still quite, yeah, working. Yeah, I think you'd need to know what the routes were but I guess you could get on top of that pretty quickly. Yeah, I mean, maybe there aren't that many barriers potentially. It's relatively, it's kind of straightforward, isn't it, much in the same way that for someone with potentially high risk of cardiovascular disease, you'd turn around and – as doctors we generally have quite a broad knowledge, particularly GPs, of this stuff. So I doubt – you'd probably need a brief period of training in it but I don't think, necessarily, it would be that difficult. I guess it would – I'm trying to think of when it might become difficult. I think, you know, if the screening programme produced more results that were ambiguous or weren't quite good – you'd hope they would stay within secondary care and be followed up rather than handed back to GPs to pick up the pieces from that, yeah.

Q: What makes –

GP9: Um…, I mean, at the moment there aren't many that do come back from breast cancer screening with a kind of vague answer. I think as it stands it works well but I guess if you're picking up more and more at an earlier age, they may become more sort of blurring. A bit like sort of PSAs, I don't know how much you've looked into that, you know, that's become definitely something, like GP to check PSA and it becomes very much an ongoing thing for the GP to then manage on top of their workload already. But yeah, I mean, with all these things, probably once it's introduced it's very difficult to go back, once you've introduced the workload for GPs, like it's difficult to claw it back. It feels like it only ever goes one way. So it's – yeah, it would be interesting. I think, I don't know what your experiences are so far from other GPs, whether they've been positive about it or not. I might need you to tell me that later but –

Q: [Laughs] I'm not going to –

GP9: You're not going to tell me [inaudible 0:18:51] you don't want to be influencing –

Q: [Laughs] Your opinions are just as valid as anyone else's.

GP9: Yeah, I know, yeah. It's just very interesting to – because I think my opinion is coming from someone who is often just parachuted in and perhaps doesn't have, at the moment, anyway – I worked in that particular practice for a year and then for the past like six months or so I've been more sort of ad hoc locum, so –

Q: Right, okay, yeah, yeah.

GP9: Perhaps I don't have as much experience on the ground as like a GP partner would comment.

Q: Yeah, but that's okay because what we're looking for is like a diversity of views.

GP9: Yeah, different opinions, exactly, yeah.

Q: It'll come out in the analysis as well when I look at the different backgrounds. Okay, great. So I'm just going to share the diagram just so it's like up on the screen, so you don't have to retain everything that I'm just going to say.

GP9: Okay.

Q: Can you see that okay? I'll just make it bigger.

GP9: Yeah, that looks good.

[0:20:00]

Q: Okay, I'm going to be looking over here because it's on a different screen.

GP9: [Laughs]

Q: Okay, so as you'll have seen, like we're suggesting that risk assessment would involve three different components to assess risk. So the first component is a self-reported questionnaire that a woman would complete and this is essentially just to gather answers to factors that we know do impact breast cancer risk. So this will be things like height and weight, family history of breast and ovarian cancer, age at first period, age of first pregnancy, oral contraceptive history and alcohol consumption. For the second component women would need to undertake a mammogram and this wouldn't be for the purposes of cancer detection, how it's currently used in the breast screening programme, it would be to assess something called breast density.

GP9: Okay, yeah.

Q: It's looking at the amount of non-fatty tissue compared to fatty tissue. And the reason why that's important to look at is that women with a higher proportion of non-fatty tissue are at an increased risk of developing breast cancer.

GP9: Okay.

Q: And then finally, women would need to provide a saliva sample so that we could perform a DNA analysis and this is to look at two different things. So firstly it would look at these multiple common genetic changes that have been associated with breast cancer risk but on their own they may not confer an increase in risk but once they’re put together, like cumulatively, that forms – that's something called a polygenic risk score. So in that instance, like, for instance, one of them has like 300 little changes in genes which can increase breast cancer risk. And then just to make sure it was comprehensive, we would also look for mutations inhigh risk genes such as BRCA1 and BRCA2 but just to emphasise that because this population we're looking at won't have a strong family history, we're unlikely to find those mutations.

GP9: Yeah.

Q: Yeah, so my question to you first of all is how would you feel about primary care collecting information from women about the list of factors in the first column, if you can see that?

GP9: Yeah. I mean, I think that's pretty – that would be pretty easy to pull together. So age at first period, age of first pregnancy, I don't see any issues with that. I guess, you know, if you look in – what were the age – what was the age range, was it thirty to thirty-nine?

Q: Yeah.

GP9: Yeah. Yeah, it's a lot of people, probably, to get in contact with and to get them to bring it back but I think that could probably be done predominantly from an admin task point of view. I mean, you could even send out a text, couldn't you, something – you know, people of that age would be pretty savvy with tech, I don't think you'd have any issues. So yeah, I don't, on the face of it, have any major concerns about bringing that self-report together.

Q: So how do you think this information would be best collected, in your opinion?

GP9: Yeah, probably something like a – you could send out – it would either be a letter or a text, potentially. In terms of getting it back, the most likely scenario would probably be something quite quick and snappy, so something like a text, you know, just outlining the – what the study would be looking at doing. I can't imagine that many women of that age would have issues with it. I think if they didn't want to get involved, having done a bit of reading, you know, it's up to them. I mean, on the face of it, I'd probably say a text message, you know, with a link to a questionnaire that then went into the computer system of the practice. But I guess there's potentially some issues in terms of like data, you know, ensuring that – but then I don't – I'm not sure why someone would necessarily – yeah, maybe not so much an issue from that point of view, yeah.

Q: So who would you envisage like being responsible for like sending that text? I'm not sure what happens in practice.

GP9: So I mean, at the practice I work at quite a bit there's sort of a data guy, as such, who tends to be quite hands-on with these sorts of things, so I'd imagine he'd – that would be something for him to get stuck into, yeah. But I think there's no reason that someone in admin couldn't do that, you know. I think to have a GP appointment set aside for that alone would be a waste of time. I mean, if you wanted ultimate sort of informed consent as to the study, though, you might – you could argue that you’d need that but I guess if you sent them a link saying, "Please click." And then further information, a bit like what you have here, I don't see any reasons why an admin person couldn't just send that out and the patient can then take responsibility.

Q: Yeah.

GP9: I don't actually – I should probably know more than I do to be honest but in terms of the current screening services, you know, thinking about what breast is like at the moment, I think it's a letter, isn't it, that gets sent out, am I right in saying?

Q: Yeah.

GP9: Yeah so, and I don't know if that's an age thing or a – but I guess you're asking for information here whereas in the breast screening programme it's very much like, please get in contact because we need to see you now. Yeah, so it is a bit different.

Q: Can you think of any potential barriers or difficulties with collecting this information from women?

GP9: Um…, I think that kind of collecting any information from people from deprived backgrounds tends to be more difficult. In terms of eliminating that, that's very difficult. I think you'd have to really push it with sort of the information programme. So I don't know what the intention would be, whether to roll this out across [place] initially or, then the UK but I guess with any screening programme it needs to be – go alongside a really good information sort of awareness push as well. Otherwise, I think it just gets lost doesn't it and people don't see the importance and sometimes it feels like a bit of a nuisance that your GP's texting you and it could get ignored, couldn't it.

Q: Yeah. Is there anything else in addition to like an awareness push that you think would help women to engage with this?

GP9: I think like the uptake initially is always going to be potentially difficult but I think from year on year people talk – a lot of it is word of mouth, isn't it, after a few years, you know, everyone's – people have talked to their friends, their family and they’re saying, "Why aren't you doing that? It's fine.” And just looking at the – I guess looking at the sort of combination of measures, you know, is it that you would do the self-reports and then it becomes a percentage that then go forward to the mammogram and the DNA or is it everyone from thirty to thirty-nine, or is that still work in progress?

Q: No, it would be everyone.

GP9: Interesting.

Q: Yeah, everyone would need – so, because the – well, the idea with the questionnaire is that even though we're asking about family history of breast and ovarian cancer, as I said before, we imagine that this co – this is for the cohort, women without strong family history. But the reason we'd include that self-report stage – it is the first step because it would screen out women who've got a strong family history. So –

GP9: True, true.

Q: So it would come up to say to them, like, oh, ask your GP for a referral to a family history clinic, like this isn't suitable for you to, like, carry on. So from that perspective –

GP9: So that – I mean, that –

Q: There is a bit of a – yeah.

GP9: Yeah, and even in that sense, that might flag up those very high risk family histories before they don't think about it and then wait and wait and – so then it might kind of produce that effect as well, which I guess would be good, yeah. Yeah, I mean, my first reaction is that there's – that's quite a lot to do isn't it for a lot of people, so I think for both primary and secondary care that would be quite a significant increase in workload. I wonder, as well, in terms of the saliva sample, whether – how like – yeah, I can just imagine certain people in my population being like, "Oh, they're taking my DNA, there's no way I'm going to give you my DNA. You're going to clone me or something." You know. There's like sort of an underlining conspiracy sort of tendency amongst certain people. But I guess they don't have to. Again, that would – the education would be really important alongside it, wouldn't it.

[0:30:33]

Q: Okay, yeah, thank you. Okay, so if we start to talk about it more as like a whole, so one model of how breast cancer risk assessment 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 answered family history, hormonal and lifestyle factors, so the data from the self-reported questionnaire.

GP9: Yeah.

Q: What do you think about primary care coordinating the process of breast cancer risk assessment in that way?

GP9: So you're saying that the initial self-report would produce a risk level and then you'd be going forwards, is that what you mean?

Q: Yeah, it's basically if we imagine – obviously the tool doesn't exist at the minute but if we were able to develop a tool where the – because obviously we take a mammogram and – well, it's not obvious, actually – well, it might not be – mammogram and the DNA, if you imagine they're coming from secondary care, it's kind of like if we were to create a tool. If we already had that information in there and then by you, like someone in primary care entering the questionnaire data, it would then generate like a risk score for you to then discuss with them. What do you think about that?

GP9: Yeah, I think that's reasonable, I think that sounds reasonable to me because that is very much in line with a QRISK, isn't it, so you're over 10%, the data shows that you're increased risk of heart attacks and strokes. Therefore, you know, I can present you the options, you don't have to take it but you have more informed consent at that point. And they can go away with information as well about the mammogram, about the saliva sample, they don't have to do it there and then, do they but I think that's how I'd see it going forwards personally. The GP would be doing the kind of data collection and then, you know, pushing it forward once it passes a certain threshold. I think otherwise, to me – it might just be sort of a lack of ambition in terms of thinking you can do all of that because I think ideally you would have that, I'd imagine, because I'd guess the results would be better, potentially, if you did all three at once. But I don't know if that sort of staggered information gathering and then advancing into the other two once you've got that, probably would be most feasible, I'd guess, yeah.

Q: So are you saying, then, that you feel primary care's involvement would be at the first stage and then you feel like secondary care should take over for the other elements?

GP9: Unless it was very much sort of an algorithmic, like the percentage is 41%, we now advise them to go to – I think if there's going to be lots of thinking about, oh, trying to explain this, I think that becomes a secondary care breast clinic sort of issue. But I mean, if it was presented like that, I wouldn't see a great problem with it, I think it would be fine on the face of it, yeah.

Q: Okay. So how would you feel about communicating the risk score and making a management plan with a patient?

GP9: I mean, we do that a lot already. So, you know, we do it – QRISK is a really good example. You know, we do sort of manage uncertainty, I'm just trying to think of other examples but like PSA as well, like it's not always absolutely clear cut but once you hit a certain score, you go onwards, you know, sometimes there’s – taking into account different things. So yeah, I think that would be okay. I've sort of back-pedalled there, haven't I, I kind of said that it’s initially –

Q: So no, yeah I’m trying to –

GP9: Yeah, initially I just want to do the first one but then I caved and said, oh, I’ll do it all. I think that's the problem, that's the problem with GPs, they're too nice, they'll take it all on and then they’ll kill themselves doing it.

Q: Yeah, so I suppose I'm just trying to get it straight in my mind, like –

GP9: What would be the line?

Q: How you – like what would be the optimal involvement of primary care in this for you and it's completely fine to say we shouldn't have anything to do with it. But yeah, it's just useful for me if you can try and kind of solidify what you think if we were to organise this, like how you think it would be best organised, whether that's – I know you mentioned before about it being like a separate service, almost run by someone else and, you know, or would you – you know, would you prefer it – the assessments to be done elsewhere and then you could deal with the management, or, you know, like those kind of different options? There's not a right answer but it's just to understand, based on your experiences in primary care, like how you feel this would fit in if at all.

GP9: Yeah. I mean, thinking about it, I don't have that – since I've qualified I've not had many discussions with women about screening, like people coming to me saying, oh – who are like in their fifties and within the cohort that are screened, I haven't had that many people come to me saying, "Oh, should I get screened?" Like people, I think, tend to make those decisions themselves. So if the GP gathered the information on the left and then the other two things were sort of automatically generated once you hit a certain level, I don't see a reason why a letter wouldn't just be sent to the patient automatically to say, please attend for further investigation. I think, you know, you'd ideally – like even in the screening programme that currently exists, ideally, yes, you'd hold the patient's hand at every point, wouldn't you and you'd call them up and say, "Oh, you know, this is a really good screening programme." But that – you can't do that for a whole population. So I think that might be the way to do it. And then perhaps you can send out texts to this particular cohort because they are young, to say, "Our records indicate you haven't taken this up, please get in contact if you feel you want to explore this further to, you know, look at what's holding you back." But it's hard to necessarily say that it would be a good idea to have a separate GP clinic just focusing on this service, because like my feeling is that there probably wouldn't be enough time in the working week for that, yeah. So if you could make it incredibly data-driven and you felt that, you know, you were confident on the numbers – and you're always going to miss a few, aren't you, that's just how it is. But if we've done the stats and we're confident with it, then I don't see why we can't just send letters out once they've completed the three. And there doesn't need to be that much GP input, I don't think, necessarily.

Q: Yeah. So what do you mean by sending out a letter after they've done all three? Do you mean the risk result or –

GP9: If, yeah, so, say – because I'm trying to equate it to the cholesterol and the 10% thing but then you are starting a medication there, aren't you, and the GP's going to be continuing to prescribe it. Which is different to sort of a one-off further investigation under a secondary care breast clinic once you've satisfied the criteria so – do you know what I'm getting at? Yeah, so I think if they've reached the threshold for further investigation in secondary care, then I think secondary care should be alerted and they should send it out themselves at that point.

Q: Okay, so are you meaning – just to get it straight in my head, so by further investigation are you meaning after they've done the three points?

GP9: Exactly, yeah, yeah, that's what I'd say.

Q: Okay, yeah, that's fine.

GP9: Because I'm just trying to see what the GP involvement would necessarily be here beyond that initial data gathering.

Q: Yeah, so we'll come on to talk about – it's basically to see whether you think –

GP9: I guess it would be crunching the numbers as well, wouldn't it, it would be, someone's got to come up with that, that number. So it's who does that as well, isn't it, that's another question.

Q: Yeah, so we'll come on to talk about – I know you're not currently involved with breast cancer risk management but there is the option for high risk women to commence a medication, so in that respect it is similar to like cholesterol.

[0:40:04]

GP9: Yeah, I suppose so, yeah.

Q: It's just asking – yeah, so we'll come onto that, to discuss about whether that would be best managed in primary care rather than secondary care. I'm just looking at my questions to see what else. So right, so I know you said there that you'd probably foresee like minimal input from primary care. Who do you think like in terms of what type of professional group do you think could be involved in this?

GP9: I think –

Q: You've spoken a lot about GPs but I'm just wondering if –

GP9: Yeah, that’s true, it's a big team, isn't it. So you could have the nurses – like nursing staff within the practice, I think, would be quite good at this, you know, they're really – they're often really good at managing chronic disease and I think they'd be absolutely fine at, you know, looking into this, they'd be good at it. But I think you'd need to keep it clinical in terms of the actual conversations going on from there. But I'd say the nursing staff are best placed if it's not GPs, yeah.

Q: Okay, thank you. Okay, so the output of the tool would also include recommendations for management of increased risk. So currently, it is imagined that women identified as being at increased risk would be able to access earlier breast screening, from the age of forty.

GP9: Okay.

Q: 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 also taking risk reducing medication such as Tamoxifen. These risk management options would need to be discussed and offered to women identified at increased risk.

GP9: Hmm-hmm.

Q: What do you think about primary care providing lifestyle advice about reducing breast cancer risk?

GP9: Yeah, I mean, I think that could be done relatively easily. I don't – again, I'm not entirely convinced you'd need a whole appointment for that. I think that could be achieved through – once you've hit the threshold that I keep talking about then I don't see why, in this population in particular, you couldn't fire out exactly what a GP would tell them verbally in the appointment via text or a letter or, you know, leaflets. And obviously, if they want to come back and speak further about it, you know, if they want to really tease out the details of it, they could do. But I don't think it would be hugely complex, you know, telling people that they need to essentially lose weight and drink less and – yeah. And it kind of – it raises questions about how much we should be sort of pushing these things on the population as well, like at a certain point you do have to just present them the information – personally I think – and then just leave them to do it. Like just constantly hounding them to come and see their GP, like where – at some point you have to just go that these people are autonomous individuals who make their decisions, hmm, yeah.

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

GP9: Um, is there anything different? [Pause] I can't – not off the top of my head. Can you think of anything [laughs]?

Q: No, I suppose I was just asking about, in your experience, like I don't know if you tend to have a lot of discussions about lifestyle in relation to heart attacks or like cardiovascular risk, whereas you might not –

GP9: That's true, yeah. I think it might be more established in the mind of a GP in particular, you know, these things are clear cut, you smoke you get heart disease, you know. But I think the QRISK tool in itself, having to crunch the numbers on that increases awareness constantly of, these are the factors to reduce and, you know, a tool like this may well, in process of doing it, improve the education around that, yeah.

Q: How often do you discuss lifestyle in relation to cancer risk?

GP9: I mean, like there's very obvious ones, aren't there, you know, you’re going to tell most smokers to stop because they'll probably get lung cancer or increased risk of quite a few different types of cancer. But I mean, broadly, you quite rarely just bring up, "Oh yeah, if you want to stop yourself getting cancer, just stop all these things." Because it feels a bit – but you may well kind of mention to people if they've come in about a certain thing and they've got obesity, you may well – I've probably said quite a few times in the past, there's lots of reasons to reduce it, including the risk of cancer.

Q: Yeah.

GP9: Yeah, but whether I specifically reference breast cancer, I think I probably don't.

Q: Yeah. That's okay, I'm just trying to think if it's – if you think that would be any different from – in a patient's mind, if you were talking about it with relation to breast cancer risk rather than things that are more established, like you said, about –

GP9: Exactly, yeah. I mean – yeah, I mean, I think it would – the more you would do it, the more it would become automatic, I guess, yeah.

Q: Yeah, probably. Okay, thank you. I think that’s that. Okay, so the second risk management strategy would be risk reducing medication. Can you tell me a little bit about risk reducing medications that you might prescribe within primary care currently?

GP9: Risk reducing medications? For cancer specifically?

Q: No, just for anything else.

GP9: Well, statins an obvious one, isn't it.

Q: Yeah.

GP9: You know, other ones, I mean, there's lots of different types – a lot of it is cardiovascular from a primary care perspective, so antihypertensives. I'm trying to think of other risk reducing medications. [Pause] I'm obviously missing absolutely tons, aren't I, there’s nothing in my head.

Q: I wouldn't know [laughs]

GP9: So I'm trying to think of what I do because I was actually at [place] yesterday. I think – you know what, I think it's because I see a lot of on-the-day stuff at the moment, so I'm not sort of dealing so much with chronic disease. But they're the ones that come to mind off the top of my head, sort of cardiovascular risk reduction medications.

Q: Okay, so, bearing in mind that, then, what do you think about primary care discussing and prescribing breast cancer risk reducing medication such as Tamoxifen?

GP9: [Pause] I think there'd actually need to be – on that in particular there'd have to be more education amongst GPs because I would feel quite uncomfortable starting Tamoxifen, that's not something that I've personally ever done and I'd want to – you know, I'd want to feel comfortable doing that before we were let loose with it, I think. And how you'd do that I'm not sure. I'm sure there'd be – you could have sessions with a breast cancer specialist, couldn't you, looking into it. And I guess I don't actually know the monitoring follow-up you'd need for Tamoxifen, whether – I'd have to look into that as well, you know, do you need to do bloods every however long? Does that then mean you'd have to do more blood pressures and – yeah. So a lot of this does – it snowballs, doesn't it and it produces more work on top of that. But yeah, in an ideal system, if you've been educated about it, you felt comfortable, the breast specialists were comfortable with it, I don't think that would be an issue. It's just whether you could fit it on top of the pressures already, I guess.

Q: Yeah. Could you tell me a little bit more about why you used the word uncomfortable?

GP9: Yeah. I mean, Tamoxifen in this context is not something I've prescribed much at all, thinking about it. I'm sure I've clicked through them like on a, you know, repeat prescription, but in terms of starting it, I've not had much experience in doing that. To be honest, I'm not sure if it's something that at the moment, is just purely secondary care initiated. I think it is, isn't it, at the moment, as far as I'm aware. So there would need to be a lot of training in that. And again, it comes down to the – if there are significant monitoring requirements, then you're starting to, you know, that’s another cohort of patients that need to be monitored by primary care, yeah. I've got my – yeah, I've got some reservations, I guess, about that.

Q: Okay. What do you think could be done, then, to make primary care staff feel more confident about having a role in breast cancer risk reducing medication?

GP9: I mean, I think that education side of things would need to be really addressed. Um…, so I think potentially, you know, seven hours with a breast cancer specialist talking about, you know, how you start it, how you talk about starting it with a patient, I mean, I'm kind of on the fence about whether that side of things should just be secondary care, to be honest. But I think that potentially comes from just a place of discomfort, like I say.

Q: Okay. And is that discomfort solely attributed to not having –

GP9: The fact I've not done it before.

Q: Okay, yeah.

GP9: Yeah, I guess so. And I'd probably have to look in greater depth at the sort of side-effect profile and the risk profile of Tamoxifen. I know there's an increased risk of DVT, you know, how much that is I'd have to look into as well. I think at some point you do have to turn round and say, sometimes specialist care need to take stuff over, in terms of the initiation in particular.

Q: Okay, yeah.

GP9: You know, you don't have GPs starting Methotrexate in people with rheumatoid arthritis because it has significant side-effects and it's a difficult drug to manage.

Q: Okay, yeah.

GP9: Yeah, but I don't know if Tamoxifen is comparable, it probably isn't, I'd have to really look at the safety profile of it.

Q: Okay. So if you thought about prescribing Tamoxifen for reducing breast cancer risk and then prescribing statins for reducing cardiovascular risk, would you consider the two to be different, are there differences that are influencing why you're having like a different reaction to –

GP9: Yeah. I think they are different, aren't they, because, I mean, every – a statin is – is so widely prescribed because you're looking at a very generalist situation for a general practitioner to take over. Whereas we are dealing with quite a specialist cohort of patients here with what is quite a specialist drug as it stands so that would be my concern. I think on the face of it, GPs could be trained to do anything but whether they should do it is a separate question. Whether it's reasonable –

Q: I’m going to play devil's advocate then, do you think primary care should prescribe it?

GP9: Tamoxifen?

Q: Yeah. Just for prevention.

GP9: My first reaction is probably no. I don't know why, it just – I think it might be coming from a place of just knowing how stressed I am often in primary care and just feeling like, no, I'm not going to – I don't want to do that, someone else can do that, actually.

Q: Yeah, that’s fine.

GP9: But I think that – it doesn't necessarily come from inherent risk of the medication, it's more a case of just feeling like the service is overwhelmed in the first place. So you're going to have to – you're going to have to expand primary care and put a lot more money into primary care or just do it in a different service, that you've funded properly. That would be my sort of feeling on it.

Q: Yeah, that's fine, thank you.

GP9: Which I know is quite defensive.

Q: No.

GP9: I'm not just being difficult.

Q: No, I just find it interesting, so I'm just trying to delve into like the reasons why. I know you probably feel like I'm just asking you why about everything but –

GP9: No, no, it's interesting. I'm kind of talking as I'm thinking. I think that's the difficulty with these things, isn't it, that I'm kind of – I haven't come to the interview necessarily with a set viewpoint, I'm just talking and finding what I actually think, I guess, as I do so, yeah.

Q: Yeah, thank you. Okay, a bit of a different question now. Can you tell me about the impact Covid-19 has had on your practice in general?

GP9: On the practice in general? So as it stands – because I've been back to [place] in the last month or so and it was largely similar to before pandemic. And the thing is, I was a GP trainee at [place] as Covid struck, so I was kind of just warming up to the job. And then in February of my year from August to August it then just changed everything, we went to just telephone phone calls, basically. So there are more telephone reviews in general but actually, it's definitely returned more to face-to-face. And there's definitely people that walk in now and I'm like, why have you booked a face-to-face appointment? You could have so easily done this over the phone. But, you know, the Daily Mail wanted it so they can have it, it's fine. Yeah, so I'm not bitter at all [laughs].

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

GP9: So interestingly, I looked at some of the stats and there has been a big drop in like breast cancer screening. In fact all the screening programmes during Covid naturally reduced but whether they've returned back to the same levels I'm not sure, actually, I wouldn't be able to tell you. I think, like we missed lots of kind of standard monitoring bloods for the best part of a year. I think that seems to be speeding up and getting back into the swing of things but I think it would have had a big impact during that time. But it seems like, you know, the phlebotomy clinics are flooded with patients now and it seems like everything's back up to speed to me personally, yeah.

Q: Okay, so how do see breast cancer risk assessment and management fitting in with your practice currently, or do you think there's a place for it in the future or not?

GP9: I think there would be but I think, as I said, that initial data retrieval, I think, could be done by the practice and then after that I think it should be relatively automated. And the patients can contact the practice if they need to. But I think if you're starting to set up special clinics for this cohort, my feeling is it probably should actually be in primary – in secondary care. You know, if they really want to talk about their concerns, just thinking about the kind of extra workload that would come out of it, because I'm not sure how many people across the UK this would impact, like what is it – do you know how many million people it would be?

Q: I don’t know.

GP9: Off the top of your head, yeah. But it would be big, wouldn't it, it would be a huge change in practice. But it could potentially be really, really good as well, so yeah.

Q: So when you said about it being automated from after the point of collecting that first lot of data, do you mean that secondary care would be responsible for dealing with the risk management side of it as well or could primary care –

GP9: I don't know. I think the Tamoxifen thing, to me just feels like that's a step too far, maybe. And when you're looking at the risk management side of things – I mean, how often would this be repeated, this sort of process? I guess that's another question, isn't it, you know, you've done one round of it there, of the three and you've produced some people that are just on the threshold of feeling like they're someone that might need Tamoxifen, might need – it's segregating those, isn't it. And the people who are 9.9 on the – 9.9% on the sort of scale as – what do you do with those, do you test them again in two or three years’ time or – what's the –

[1:00:27]

Q: Yeah.

GP9: So it probably does need discussion, doesn't it because people are going to come – patients are inevitably going to come back to you saying, "This risk score's 9.6, what does this mean?" So it will generate – it will actually generate work, won't it, it will definitely generate consultations as well. I'm not sure there's a right answer on this one.

Q: Where do you think those consultations should be, though, in primary care or secondary?

GP9: Yeah. It also depends on how many it will generate. So like if it's producing [pause] – I think my gut feeling is it should be in secondary care, actually. Once it gets to that part, I think fund a proper service for breast clinic for this and if the numbers are absolutely huge, then maybe you should question whether you should be doing it in the first place. Is it a screening tool that's that good at that point? Do you understand what I mean?

Q: Yeah, yeah.

GP9: So yeah, because if you – I'm just trying to think, from like a PSA or a – PSA is not a good example because there's not a screening programme for it, is there – but, you know, if your uptake was good and it then produced lots of people that you had to have these interventions with – for any of these screening programmes, it would be a disaster because you'd just be – it would produce an intolerable workload for the whole of the NHS, whether it's in primary or secondary care.

Q: Yeah.

GP9: So you'd need it to be good enough to – but, like I say, there'd be lots of people just below the level or – who would want it explaining. So where that conversation takes place is not an easy question to answer.

Q: You're not going to answer it, are you? [Laughs]

GP9: I'm not actually, I'm really on the fence, aren't I? I think but it's coming from a place of knowing the pressure that primary care is under and, as it stands at the moment, I think it should probably be secondary care but, if you properly funded primary care, I think we'd be happy to do it.

Q: Okay, yeah, great thank you. So finally then, are any other issues that you've not previously mentioned, that you think would be important to consider when setting up a pathway for breast cancer risk assessment and management activities for women in this age group?

GP9: Setting up a pathway?

Q: Whether that's in primary care or not, like just is there any other issues that you think we should be thinking about?

GP9: I mean, there's always sort of capacity issues, aren't there, you know, the people who don't have capacity to make decisions and then that would produce, you know, consequences in terms of having to do these things potentially in best interests. So that might be difficult if you've got like a learning disability population in your –

Q: Okay, yeah.

GP9: And you might have more of that than potentially in people who are older, sixties, seventies, I don't know. I can't think of anything else right now, no.

Q: Yeah, that's fine, okay. Okay, so that's all the questions I had. Thanks for your time, I really appreciate it.

GP9: Okay, no worries.

Q: Is there anything you thought you would talk about today which you haven't had a chance to say and you want to mention?

GP9: No, it would be nice to ask you a few questions just about sort of the way you see it going and what stage you're at of the process.

Q: Yeah, we can do that when I stop the recorder.

GP9: Yeah, of course, yeah [laughs]

Q: Then the transcriber doesn't have to sit through that [laughs]. What was the most important thing that you've told me today, do you think? I know you've said a lot but the take home message –

GP9: I've said a lot, haven't I, I've said a lot. I guess it's sort of trying to give an impression of the reality of general practice and that there do have to be limits on what primary care can just absorb in terms of extra pressures. I guess that would be my very negative take-home message [laughs]. Sorry.

Q: No, that's fine. On that note, I'll stop the recorder.

GP9: Yeah [Inaudible 0:1:05:23]. Good luck with your study.

[END OF RECORDING – 01:05:25]