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Interviewee/s: GP5

Interview Date: 21.02.2023

Interviewer: Q

Q: Okay, so that's recording on both devices now. So just to start off the interview, are you able to just quickly introduce yourself, a little bit about what your profession is and what area of [place] you work in?

GP5: Yeah, so I'm a senior partner at a practice in [place]. My name's [name], I'm a trainer and I have perhaps particular interest in women's health because I've been a GP for a very long time and I'm a woman. And I work in [place], which is [place], sort of north of [place], with a very mixed population, high deprivation. We have a big [name of ethnic minority group] population and lots of elderly in care homes as well, lots of mental health issues, and about half of my patients are female.

Q: Okay, great, no, that's great, thank you for that introduction, it’s really helpful background information, thank you. So as a researcher who does not work in primary care, I'm not familiar with what happens in practice, so 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, either about their breast cancer risk or about breast health, and talk through what happened and what you did, if you've got that experience.

GP5: Yeah, I mean, I think I would struggle to pick an individual, but I think it's fair to say that women of all ages worry about their breasts. They worry about lumps, and it is quite common for people to have a family history because, you know, let's face it, one in eight woman get breast cancer. So, and, you know, I think probably because of my personal knowledge of friends who've had breast cancer, you know, I think it does keep you very switched on to the fact that it's not an old lady’s disease. And so if a woman presents with anxiety about maybe having her mum, sister, aunty, granny, whatever, having had breast cancer, I would – and they want to know what their risk is, I refer them to the breast cancer – there’s basically sort of a family history clinic and you can refer them there. Because I don't always have the details about the other women from their family, I don't know if they've had BRCA gene testing or anything like that. But, if I have got patients who have got breast cancer, I have a tendency to say to them, you know, have they done genetic work-up on you, you know, therefore are you at higher risk of having passed on dodgy genes to your kids? So those are conversations I think I actually have to have quite frequently. I mean, if they've got a breast lump, you know, obviously they get referred off – if I think it feels worrying, on a two week wait. But if it's more about, I'm worried and, you know, I haven't got a lump, I haven't got anything specific about my breast that's worrying me, but this is the story in my family and I'm scared, then it's great that we have a family clinic to refer to.

Q: So how do you feel about having those interactions if you think specifically about the younger age group?

GP5: Well, I mean I like it because they're being sensible and proactive, you know, they've often had a read or a think or they might just be panicked, you know, just full stop panicked. And I think the thing with breasts is that they're very – it's an emotive thing, full stop, because people generally don't know whether a lump, pain, skin, you know, anything to do with their breasts is, as far as they're concerned, something worrying and, you know, which it obviously isn't always. But it's just one of those things that's enormously highly emotive in people's minds, they get very anxious about.

Q: Okay, great, thank you. Okay, so breast cancer becomes more common in women in their thirties and it's 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 at being at increased risk. So currently there's 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 and 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 one potential approach is for breast cancer risk assessment and some aspects of risk management to be conducted in primary care. But first of all, if you could just 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.

GP5: I mean, I don't have an issue with it. For me, the real anxiety is, if men knew that they had a one in eight, one in nine chance of having a cancer, they would go ballistic, there would be a brilliant screening thing, you know. I just feel as though women have got a bit screwed, because, actually, that's spectacularly high risk, you know, and I think if they've got a family history, an increased history or something, so their risk therefore goes up to one in four, you know, it was already really high. I think this is the thing I don't quite understand, you know, I look around all my mates and go, you know, one in eight of us, one in nine of us are going to get breast cancer, and in our lifetimes. So, and I think – but that's just the thing, I think people just are unaware of how incredibly high risk it is. And I'm almost anxious that if we really crack on about it enough, and we just go, you, you've got a one in nine chance of breast cancer, I think, you know, the panic – I just think it's funny, almost, that it's already incredibly high risk. So if you raise somebody's anxiety with like, you know, you just go, oh, well, do you know what, because of your genes, your family history, your whatever, you've got an increased risk, I mean, I almost think it's funny. Which is part of the reason I signed up to this, because I actually just thought, shit, it's already ridiculously common. And so if you don't tell somebody, well, actually, you've got a one in four chance, when they're thirty-two, that's awful. But it was already awful just by being a woman. So, you know, if it means, therefore, that they are more switched on to being able to self-check or, you know, they've – the raised awareness means that they are open to a system that's going to be able to screen them or check them out or reassure them, then I'm game on for that. You know, because I think mammography itself is not as amazing as we think, you know, there's false positives and negatives and things in that. So I'm always anxious about the idea of putting somebody into a screening programme if it's a bit of a shit screening programme. So, like, you know, PSA for prostate cancer, it's not as brilliant as we think it is. So I think that's kind of my point, if we're going to raise awareness and really, actually, just go, you've got a really high risk, then we've got to be able to have a system in place to be able to deal with that, you know. I don't want to tell you you've got a one in four chance of breast cancer, but, you know, there's nothing we can really do about it, you can't have a mammogram till you're fifty.

Q: Yeah, okay, yeah, that makes sense. Do you have any specific thoughts, if we think about, if you offered this specifically to women aged thirty to thirty-nine, is there anything that springs to mind as any concerns or benefits you feel that that would have?

GP5: Well, I mean, yeah, there's lots really. Because lots of women don't start breeding till they're older than that. It might mean, for instance, like my girlfriend who died from breast cancer, who went to the doctors several times during pregnancy with a lump in her breast, and everybody ignored her. I mean, she didn't actually have a family history so that's kind of, in a way, irrelevant. But I think just that whole maybe an increased awareness, you know, knowing what you're looking for is a good thing and I think it potentially would mean, therefore, that let's say you found a lump, rather than people going, “Well, you're only thirty-three, it probably isn't anything,” you might take it more seriously, particularly if you knew what your risk was. I mean, so you can see just coming back to what I was saying originally though, that on the grounds that your lifetime risk is one in eight or something, I've never actually found myself going, “Oh, well, you're only thirty-three, it's unlikely.” Do you know what I mean?

Q: Yeah.

GP5: I think – but I'm not sure that that is representative of all doctors, because I think it's a little bit like lots of things, you know, somebody presents with bleeding from their bum and they're thirty-three, we should still be thinking cancer, even though it's much less common in a younger person.

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

[10:04]

GP5: It comes down to what ongoing support there is, you know. I'm afraid – it's like everything, if somebody's screened positive for something, is the infrastructure there to support them? You know, primary care is constantly being asked to do more and more things, and I think it's not necessarily such a bad thing, because the wording is in the title of our jobs, you know, we are primary care physicians. So some of the work that we do should be about early identification and screening and education and prevention, you know, in a primary, preventative way rather than secondary. But, you know, the whole deal is, you know, is it going to be vast numbers of people, is it going to be – take up a lot of time? If the system is put in place, would there be the information available, you know, the back-up to pass them on? You know, so for instance, like there is in other screening programmes, you know, if somebody has – is sent for when they're fifty, and I've had lots of patients like this, being sent for their mammogram and found that they've got an abnormality, the system mops it up and deals with the patient, in effect, they get taken out of my hands. And also, when you say would primary care be happy, I don't know whether you think that primary care is already doing, you know, the breast cancer risk and bowel cancer risk because, actually, they are sent for, and even smears are sent for centrally. So, although it's a primary care screening programme, it isn't – they're not sent for by me, that I have to do – obviously I have to do the smear, but I wouldn't have to do the mammogram. Do you see what I mean? So in theory it's a primary care thing but lots of those other screening programmes come centrally, so I only get involved after diagnosis, if you like, or I'm told they've screened negative or positive.

Q: Yeah. So how do you think it compares to that, then, if – so you mentioned like bowel cancer and smears, would you see this working in a similar way?

GP5: Yes. I think it would actually have to because I haven't got the initial data to identify that that woman is at higher risk in the first place. Because although I might have your medical data, I don't know about your mum, I mean, unless you've told me, and, if you told me your mum had breast cancer when she was thirty-two, I would already be referring you. But if I don't know about your family members or your genetics, therefore I don't know you're at higher risk. I can't invite you to that screening because I don't know. So if there is a central somewhere or other that just goes, [name]’s got this, that and the other risk factor, she should be screened, I don't mind you being screened for through primary care in the way you would be being sent for a smear.

Q: Right, okay, yeah, yeah, that makes sense, yeah, okay. Yeah, so some of the questions that we're going to come onto is thinking about whether you'd be happy to be more involved than that, so we'll come on to that. But the next question is around, yeah, a little bit more about that I suppose, what are your immediate thoughts and reactions to primary care involvement in breast cancer risk assessment and management? So in terms of how acceptable do you think it would be.

GP5: I mean, in a way I'm – perhaps we've already covered this, I think my whole point is it's a really common disease and I think it should be being screened for, and I think probably having mammograms at fifty is too old, you know, I would like to see it happening earlier and, if there's higher risk, earlier. And to be truthful, that is what happens, but I only know about it if the patient brings it to me, whereas – yeah, I don't think I have an issue, if somebody – if we were told we had to run some kind of algorithm through our IT system, you know, once a month or something to look for higher risk something or others because you know about some genetic something or other, then brilliant, you know. I'm not sure that that – if it was a quick search or something and then we had to identify and there were just a very few of them, I can't really see that anybody would say that was a problem.

Q: Okay, cool, thank you. So I'm just going to share a little diagram with you just because it's easier than me talking through it. So I'll just make that bigger. Can you see that?

GP5: Yeah.

Q: Yeah, great. So risk of developing breast cancer is best calculated with a combination of three different measures. So the first one would be a self-reported questionnaire and this would be getting information around breast cancer risk factors. So this would be mostly self-reported on things that we know are associated with increased breast cancer risk, 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. The second component is around breast density, so the measure of the amount of non-fatty tissue compared to fatty tissue in the breast, because we know that women with a higher proportion of non-fatty tissue have a higher risk of developing breast cancer, and this would be done through a mammogram. And then the final component would be obtaining a saliva sample to perform a DNA analysis, and this would look for polygenic risk – the output of this would be a polygenic risk score, which is combinations of multiple common genetic changes into a single score. And then it would also look for those mutations in high-risk genes that you were talking about earlier such as BRCA1 and BRCA2. So I suppose my first question is around – so in order to assess breast cancer risk we would need to collect the information in this column.

GP5: Yeah.

Q: How would you feel or what do you think about primary care collecting information from women about this list of risk factors?

GP5: I think it would be fine. At the moment we don't – you know, NHS health checks and things normally kind of occur at about forty and in theory there's like well women and well men checks and things. We don't do any of that, you know, unless somebody actually presents proactively at the practice because, in effect, there isn't time to do all that kind of stuff. There is, and this is partly thanks to Covid, there is now much better ways of communicating with patients, like doing questions that you can just send them on their phones.

Q: Okay, yeah.

GP5: With this brilliant, I don't know if you've heard about it Accurx and things. And so it's very easy, actually, for me to send that questionnaire, ping to their phone.

Q: Okay, yeah.

GP5: That would be a very easy thing to do. When the results come back to me it would be nice if each of those individual things was something that coded, so that when it came back into the patient's record, it coded, so that I could then search for that data again.

Q: Okay, yeah, hmm, mmm.

GP5: So, you know, if that tied in with our IT systems, that would be brilliant because that would be quite nice. You know, when somebody registers at the practice, you see, you ask them things like is there a family history of any conditions and things. You wouldn't normally ask the menarche and pregnancy thing. So those other things would be – and, but you would ask about alcohol. So some of that data would already be on the records, anyway, that – so that wouldn't be difficult.

Q: So what is your experience of people actually completing the questionnaires when you send them out on a phone?

GP5: It's quite high, actually, particularly younger people who are – who have mobile phones. If you stick something like this in the post, a bit rubbish.

Q: Okay, yeah. So do you foresee any key difficulties or barriers to either – to collecting this data, basically?

GP5: Well, yes, if they don't reply, they haven't replied, we can't make them. Sometimes it's difficult because lots of younger people change their mobile phones like they change their knickers and you haven't got the right number for them and that would be a block, potentially, to sending it. And language probably is less of an issue, but I think you need to bear in mind language and cultural sensitivities as well, because there is a possibility that some of my patients – there would need to be some preamble maybe, do you know what I mean? Saying, this is – your doctor is keen to make sure that you're not at increased risk of breast cancer. Could you kindly answer these questions, or whatever, this would only be stored on your records. Do you know what I mean, it would need to be something like that, so that they felt safe sharing the information.

Q: Yeah, that makes sense, okay, thank you. Do you think that there's anything else that could be done to encourage women to complete that, other than what you’ve just said about including like a blurb bit?

[20:00]

GP5: Yeah, I think blurb is good, so they know it's safe and it has actually come from the GP and not from some dodgy data gathering – I don't know, some PhD student or something.

Q: [Laughs] Okay, anything else?

GP5: No, I think that's it.

Q: Okay, cool. Okay, so if we think about it more in relation to the whole – the three components, so the whole process of breast cancer risk assessment, so one model of how breast cancer assessment could work in primary care is the development of a risk assessment tool similar to QRISK, that you currently use for cardiovascular risk. So for –

GP5: That's what I was meaning would come out of those questions and that's why we say they would all need to be things that coded, because that's the whole point, QRISK works out because it's got a code for the cholesterol, a code for family history, a code for blood pressure, a code for smoking, a code for diabetes. So that's what I was really saying, your questions, though, would have to have a code that was useful for working out the algorithm that said, oh, yes, this woman's got an increased risk.

Q: Okay, yeah. So, for example, if scores for mammographic density and genetic risk could be fed into this tool and a risk score generated once someone in primary care has entered that list of factors that I mentioned, like family history, hormonal and lifestyle. Or if they've got it in their record, anyway, primary care would then be responsible for communicating the risk score and making a management plan. So what do you think about primary care coordinating the process of breast cancer risk assessment and management in this way?

GP5: I think if there are too many variables you're making it difficult. If the answer can only be worked out if you've actually got fifteen bits of data or something, then you're on a sticky wicket. If there's only five and they're easy to achieve, then that's going to make it easier. If one of the essential ones is the mammography, then you're on the back foot already because I think you're basically – you're suggesting people have got to go for mammograms in their thirties when they're asymptomatic. It's one thing to answer some questions online, but getting people to engage with asymptomatic screening, in my experience, varies between about 30% and 70% uptake, depending on how easy it is to do. If you send a thirty-two-year-old woman who has a job and a life and children for a mammogram appointment for 3 o'clock in the afternoon, she's not going to go. So I think the – you know, the mammography bit of it would be the tricky bit. The saliva thing would be – again, I mean, you've got to see them physically, but it might be that you'd get a better uptake for that if they were sent the saliva kit, that they sent off in the way you do for poo testing for bowel cancer. But do you see what I mean, you're actually – you've got three different sets of variables there. You've got questions and your mammogram and the saliva test, most screening programmes involve one thing and one appointment. So you're really, really upping the ante here, that's a lot of things to expect from this busy woman to be doing.

Q: What do you think we could do to encourage participation in it then in terms of encouraging women to attend the mammogram? If anything.

GP5: Well, it's an interesting one, because I know from some of the other work I’ve been doing in cancer that if you give people an opt-in to go for an appointment, that's like we've been doing around the targeted lung health checks, I think they'd be much less likely to opt in to doing that than if they're actually sent a physical appointment. But I just wonder whether the group that we're talking about here, it might be more difficult. You know, I don't know, because I think – I don't know what the uptake is that you would say you're seeing in women over fifty for mammography, but maybe if it was something that was actually a very – a national programme, if you like, and everybody knew, like they know they go for their first smear when they're twenty-five. If everybody – if all girls knew that when you were thirty you would be offered a mammogram and a saliva test as part of a screening programme for breast cancer, that might be different, you know, if it was something that they knew everybody did.

Q: Yeah, okay, yeah, that makes sense, thank you. So how would you actually feel about if you had to communicate the risk score for the output of that tool and discuss with a woman about making a management plan to deal with that risk, how would you feel about doing that in primary care?

GP5: I wouldn't have an issue, we do stuff like that all the time, you know, I have to talk about QRISK and statins with people, talk about – yeah, well, all sorts of screening things, if they ask why or how, whatever, and explaining what risk means is bread and butter in primary care, really. Explaining to somebody, you know, their risk of getting a DVT on the pill or their risk of having Down's Syndrome in pregnancy and, you know, these are the kinds of – we do – we have to really talk quite a lot about – and I think we probably all have our own ways of doing it, but, you know, whether it's a chart of lots of little green people and one red person to represent, or you talk about out of – you know, we all have our ways of talking about risk. I mean, some people will talk about, you know, winning at the races or, you know, putting on bets. I think it kind of comes back very much, though, to what I said to you at the very beginning; that women's breast cancer risk is already really high and so actually saying, do you know what, your risk's really high just by being a woman, but yours is even higher, you know – but that – I don't think that's a big ask, again, you know, it's what we do.

Q: So would you feel any differently discussing breast cancer risk in comparison to some of the other risks that you talk about?

GP5: No, no. Only in so far as I – sorry, I feel like a broken record.

Q: No, no, it's fine.

GP5: Only insofar as the fact it's already bloody common and I think if a thirty year old woman knew that her breast cancer risk was one in four, you know, that potentially is going to then impact on, should I take the pill, should I get pregnant, when should I get pregnant, do I need to have a mastectomy now. You know, it would raise lots of potentially enormous questions. And that would be my only real issue, that if we are faced with those sort of figures and facts, are we the people who should be telling them what their options are? You know, I think you would need a nice robust system where – you know, like we do with the positive HPVs on a cervical smear. Those patients get screened straight into – you know, they get an appointment again in three months’ time in the hospital. So I think that would just be my only anxiety, would we have all the information that we would need to be able to potentially give this woman who was told that her chance of having breast cancer was 100%? Because she would say, you know, oh, my God, can I get pregnant, can I go on the pill, should I – you know, what if I've already got it, you know.

Q: So do you think having that conversation with someone who had been identified as being at increased risk is primary care's responsibility or –

GP5: I think it probably ought to be, from what you're saying, no, I think that probably at that point should be from a specialist kind of a set-up. Yeah, because I think that is quite scary stuff. I mean, that's almost like telling somebody they've already got cancer, you know, if you're told you've got a one in two chance of something, that's pretty much certain, isn't it? And I think – so, for instance, with something like – I mean, like Huntington's chorea, where basically you've got a one in two chance of having it because of your genes, then from primary care trying to counsel somebody about whether they should go for the genetic test or not would be really hard. So I think, you know, at that point that's a specialist geneticist bod who would do that thing. And that's why we have the family clinic, you know, because when people have ostensibly got an increased family history of something, you know, you’re like, okay, you've got an increased family history, off you go to the clinic. You know, those questions are too complicated for me to be able to answer you.

Q: Okay, yeah, fair enough. Okay, so if primary care were responsible for communicating the risk score, at least, who would you envisage taking on that role at your practice?

GP5: It would be a GP, yeah.

Q: And why is that?

GP5: Well, I don't – I think it – that wouldn't be the – I don't think there's anybody else in the system to do it, you know. No, that's it, I don't think the nurses or HCAs, you know, there isn't anybody else.

[30:01]

Q: Why would you –

GP5: Maybe a trainee doctor, but it should be a doctor, yeah.

Q: And why would you say that?

GP5: I think, because of the gravitas of the situation and also, it would be the doctor that would have to do the referral. And, yeah, I think – yeah, that’s it, I mean, I think our nurses tend to do more sort of chronic disease management and they might do vaccs and ims and smears and things, but they don't tend to be the one that break bad news, for instance.

Q: Okay, yeah.

GP5: So, in effect, that's what this potentially is, isn't it?

Q: Hmm, mmm. Do you think there's any scope for any other people to be involved in it if they had extra training, or do you just feel like it should always be a GP?

GP5: [Pause] No, I think it should be a doctor.

Q: Okay, no, that's fine, yeah, okay. Yeah, we're just trying to understand like how it – because I'm speaking to different primary care providers, it's just trying to understand that, what would everyone do because we're wary of probably asking the GP to do a lot of it.

GP5: I know, I don't know, and I was actually thinking, maybe if you were asking a younger doctor or a locum or somebody, because I know I'm very bad, actually, at remembering that I'm – you know, I'm not the most important person in the world and I'm the only person that can do anything.

Q: Yeah, yeah.

GP5: You know, I'm not very good at farming out work. But I do think in this situation this is a little bit like, you know, who's going to contact the patient to tell them they've got bowel cancer, you know, and needs a two week wait. And I think, from what we're saying here, this is a very similar scenario, so it should be done by a doctor of some sort, probably.

Q: Okay, thank you, thanks for explaining. Okay, so if you were – so if a woman had undergone breast cancer assessment and you were going to be communicating the risk score and maybe talking about management, if it wasn't at that really high level of risk that you mentioned about referring, what would be required to take on this role successfully or what would make you feel more confident in terms of confidence, maybe, in the tool or in having that conversation with women?

GP5: I think in primary care we're in this sort of trusted position, patients do generally think we know what we're talking about and that we will do the right thing by them, so that's why it's a sensible place for it to happen. But it all just comes back to the fact that it's such a common condition in the first place, that we take it very seriously, anyway. And I think if it's about saying to somebody, well, your risk has gone up from one in eight to one in six, it's all ridic – if the risk actually was one in a hundred in the first place and then you found out it was one in eight, that would be completely different. But can you see what I'm getting at?

Q: Yeah, yeah.

GP5: I feel like I keep coming back to it, it's one of those things that’s very high on people's minds and agendas, anyway. But I suppose – you see, we don't – well, midwives do the sort of Down's risk thing and there's a very clever sort of algorithm of, when you're forty your risk is one in forty and when you're forty-one it's one in thirty and, you know – so you can actually give these kinds of figures and show graphs. And in this situation that might be the thing, if there was a useful graph or information that I could share with, well, there's this but the chances are, you know, that sort of thing, yes, if we were well informed, yeah.

Q: So is there anything about your experiences with QRISK that would inform like what you would want from a breast cancer risk assessment tool?

GP5: So the thing is that, with QRISK, we use that to inform decisions about medicating somebody about whether they – what their 10 percent – you know, if they’re at risk of having a heart attack in the next ten years is over 10% and, I mean, it actually is a very – it's quite an annoying thing to have to do because basically, as people get older their chances of having a heart attack increase anyway. So, you know, sometimes those are – and in a way it educates what you might say in this situation, because one of the things that we actually say to that person is, you don't have to do anything, you know. So in some respect it's a similar kind of a concept because it's going to be, well, we could offer you this, this and this, you know, these are your options, these are the facts. You can make your own decision off the back of that. That would be the way I tend to be about those, yeah.

Q: Okay, thank you. Okay, so the output of the risk assessment tool would also include recommendations for management of increased risk. So currently, it is imagined that women identified as being at increased risk in their thirties would be able to access earlier breast screening from the age of forty. In addition to this, two strategies that have proven benefits 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 a 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?

GP5: Yeah, well, it's what we should be doing anyway, I think that's fine. I mean, the Tamoxifen thing, my understanding is it is potentially going to be offered to women who've got a one in four chance or above. But I think that that's complicated, it's not like taking a statin, you know, if you take Tamoxifen it impacts on your decisions to have children and contraception and horrible side-effects and all sorts of other shit. So I think that probably ought to be happening in a more specialist scenario. I don't – I think that's probably beyond primary care then, it's getting too complicated. If – yeah, and, actually, I suppose it's one of those things, that if it was a conversation you were actually having regularly it would be a bit different, but I would like to think that it's not going to be many. And actually, from what you're saying, you know, if I have a patient who’s got that kind of strong family history, they start screening them, they start doing their mammograms when they're in their thirties, never mind forties, you know, that does already happen. And so, I suppose, in a way I've already been having some of those conversations.

Q: Yeah, so I suppose it's because this group of women that we're looking at don't have a family history.

GP5: Yeah.

Q: So they – the only way through to accessing like the earlier screening and medication would be through completing the risk assessment. Okay, so obviously you've told me a little bit about that you obviously prescribe statins for cardiovascular risk, I'm just wondering if you can – I know you’ve touched on it a little bit there, but it's interesting for me to understand more about it, is how is that different to prescribing Tamoxifen for reducing breast cancer risk, is it –

GP5: Well, I think I've already just said that, because basically, you know, statins are relatively safe, they have relatively few side-effects, you can monitor them easily, you can make lifestyle choices first and you don't have to take a statin. So yes, in a way, they don't have to take Tamoxifen, but I would have to be able to tell them the risks and benefits. And there's a lot more research has gone into statins, excuse me, than there has been with Tamoxifen. So I – you know, I would need to be able to quote all sorts of facts and figures at them. But, as I say, it also would be very complicated because it would be – you know, when they start saying, well, so can I still have children and can I still breastfeed and can I still – you know, what contraception? It's complicated, you know, Tamoxifen's a shit drug, you know, being menopausal's crap. I spend most of my primary care days handing out HRT, making women menopausal is a horrible thing to do.

Q: Okay, yeah, yeah, obviously, yeah, okay. Is there anything that could be done to, do you think, increase the likelihood of primary care being involved with risk reducing medication or do you think it's just that it shouldn't be being done there?

GP5: I would like to think that the numbers of people are actually going to be much lower than, for instance, it is about statins and things. So I think if it's one of those things that became humdrum, it was like, “Oh, bloody hell, you as well, everybody's on Tamoxifen,” that would be slightly different. But I think if it's – you know, we have conversations with people that we put on GNRH analogues, which are drugs that block your hormones because they've got prostate cancer or they've got endometriosis, and that's very different because that's actually about actively treating something rather than preventing. And also, you've got the back-up of the team at the hospital, you've got the breast cancer team or the prostate cancer team, you know, you've got named nurses. And that's the thing, they have like a named nurse and that's what they do all day long, is talk to people about stuff like that, whereas I don't think in primary care we've really got those skills and time and stuff, yeah.

[40:35]

Q: That's fair enough. So we'll just jump back a little bit to lifestyle. Do you think there's anything different about providing lifestyle advice with respect to breast cancer risk in comparison with other diseases?

GP5: No, no. No, I mean, that's our job, that's our bread and butter. We should constantly – you know, if somebody comes in who’s overweight or unfit or smells of fags, you know, it's very much our bread and better, is, do you smoke, do you drink, do you take regular exercise? Sadly, the thing that I would actually say is that everybody that I know who's had breast cancer has been skinny and doesn't drink, so, you know, sometimes they get very upset. And, of course, that's one of those things that patients will say, “Well, my dad died at ninety-six and smoked forty cigarettes a day,” you know, those are the kinds of conversations we have all the time.

Q: Yeah, okay.

GP5: So yeah, I can't imagine anybody would find any – you know, that's bread and butter.

Q: Okay, great. Okay, yeah, so there's nothing around any barriers to doing that? No, okay, great.

GP5: No, and to be fair, that could be done by nurses.

Q: Okay. Okay, so you mentioned earlier on about – you mentioned about the impact of Covid-19 being about being able to send these questionnaires out on phones, I'm just wondering if you could tell me about the impact Covid-19 has had on your practice in general?

GP5: Oh, bloody hell, where shall I start? So, well it has meant that things like screening has gone tits up. Oh, my goodness, perfect, perfect use of the term, because the mammography thing, for instance, went wrong, you know, the whole breast cancer screening van thing disappeared, and so everybody got behind on that. People have been coming to the surgery, you know, less or thought we were closed. And I think we have actually found that we've got behind on lots of chronic disease management and therefore potentially having a grip on people who were at higher risk of all sorts of things. So I think that we’ve certainly found that all of our patients with chronic diseases like diabetes and heart disease and things, have come to the practice less. They've taken their foot off the pedal in terms of all of the lifestyle things, you know, they're having less exercise, they've been smoking more, they've taken less care of themselves. It's a bit of a generalisation, but that's true. I also think, though, that people have got much better about communicating through phones, text, Accurx, video calls. They're getting cannier about responding to things online, we've been sending them links that we perhaps – you know, in the old days we might have given them a printout about something, now we ping them a, have a read about statins, you know, and let me know what you think. So I think, in some ways it's potentially been empowering for the patients to self-care better.

Q: Yeah, yeah. So what impact – you touched on it a little bit there, but what impact, if any, do you think Covid-19 has had on risk assessment and prevention in particular?

GP5: Well, it's got worse because they're not coming in. So we've not been doing new patient checks, for instance and trying to get people back involved in that, so that you actually do do their risk assessment and ask them about their, you know – lots of information that you were talking about just then, that ordinarily we would do. You know, if you see people less, you have less contact with them, you're not going to have much data, are you?

Q: Yeah, so what do you envisage, then, in the future, do you think, is that going to be a long-lasting thing?

GP5: No, I don't think so, because I think, in some ways the empowerment thing means that they will be looking – I think we're catching up, basically, yeah.

Q: Yeah, okay, okay.

GP5: I think we do stand a vague chance of getting back to where we were.

Q: Okay. So do you think there is a place for breast cancer risk assessment and management fitting in with your practice currently, now or in the future?

GP5: Yeah, no, I mean, I think it's just going to be another thing, another screening, another, you know, hurdle or whatever you call it, hoop another hoop to jump through. And, you know, there are lots of things that we get incentivised for, QOF and things, so, if it became another one of those sorts of things that would be – that would help.

Q: Yeah, okay. So do you think setting up a pathway for breast cancer risk assessment and management activities in primary care for women aged thirty to thirty-nine years is a worthwhile idea?

GP5: Yeah, I mean I don't know what the actual figures are, and I think that all of these sorts of things potentially increase anxiety amongst the population, so if we're ultimately looking to do – so a screening programme that actually ultimately raises anxiety and costs a fortune and lots of false positives and der, der, der, only to save – only to pick up, you know, one case of breast cancer, then it's a ridiculous thing to do. But if there genuinely is the need and by doing all this shit we can actually prevent people from getting breast cancer in meaningful numbers, then, I think, yes, prime.

Q: Okay, hmm, mmm. And so just to reiterate then, is your – would your idea be that primary care's role would be similar to their current role in like cervical screening for example?

GP5: Yes, other screening programmes, yeah, which we're happy to encourage people to do because they make sense.

Q: Okay, yeah. So finally, what other issues do 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?

GP5: We'd just need to know that the support mechanism was there. You'd have to have named nurses or, you know, an easy access to the family clinic thing, you know. If they picked up – if they screened in positive and then they had to wait two years to see anybody about it, that would be useless.

Q: Okay, okay, yeah. Anything else that you've not already mentioned, do you think?

GP5: I don't think so.

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

GP5: No, I've kind of surprised myself by my vehemence, actually. But, you know, it's great – it's great that you guys are looking into stuff like that and I'd be really fascinated to know about the outcomes, really, and, you know, I'm assuming you're doing it because, actually, it will potentially make a difference. And I've seen too many patients and friends with this, you know. Ultimately, the earlier we can pick it up and work out what people's risk factors are, the better. So thank you for inviting me.

Q: It’s okay. And finally, what was the most important thing you've told me today, do you think?

GP5: We're all going to get breast cancer [laughs]. No, I think it is – you know, it's one of my personal bugbears, but it – you know, I find it astonishing that it is such a common condition and I think that we should be much more switched on to it than we are, and anything we can do to reduce risk, the better. So –

Q: Great, I'll stop the record–

GP5: – thank you.

Q: I'll stop the recording now.

GP5: Brilliant.

[END OF RECORDING – 00:48:41]