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**START OF TRANSCRIPT**

Facilitator: All right, great. Are you aware of the new guidelines around using low-dose aspirin to prevent bowel cancer?

Interviewee: Ah, when you say new, I think they’ve been out for a while, a year or so, haven’t they?

Facilitator: Yeah.

Interviewee: So yeah, absolutely. The research - there’s several research studies which show its benefit, and which age groups and the disadvantages and all those issues. But yeah, it’s very interesting and I’m glad it’s also related to the Framingham work. You can look at cardiovascular risk disease as well and [between] colorectal cancer prevention they seem to be almost the same sort of preventative strategy, so that’s sort of helpful, I think. So, I’m aware of the concept [laughs].

Facilitator: How did you become aware of them?

Interviewee: Well, I have research feeds, so [QXR site]. I get heads up - so these are articles that are collated and curated by specialists in their area; so, there’s one for cardiovascular health, one for cancer, one for gastrointestinal, one for psychiatry. These are very useful because they just tell you the latest [dates] and they’re actually summarised by a medical journalist, I suppose, in the top of their field. The cardiovascular guy just lives down the road here, so it’s quite helpful. Also, the gastroenterology. So, sort of know these people and it’s great to actually be reading these things. It’s really guideline summaries.

Facilitator: Okay, yep. Can you tell me a little bit more about what you know about the guidelines specifically? I know that you said you were aware of them and when they came out.

Interviewee: Oh right, so, I can’t remember the names of the studies; acronyms are not easy for me. But the upshot of the research was that when you used a target group, I think it was 50-year olds, if you assessed - let me go through it to get it exactly right. That there was a benefit in adding aspirin 100 milligrams, it had to be taken - had to be commenced in a particular period of time. I think it was 50 to 59, or was it, yeah 50 to 59, and had to be taken for - oh some of the studies said two and a half years, others said 10 years, but I think, that was a confusing thing, I’m not too sure. I think it was two and a half years within that 10-year period; it had to be commenced in that time, and that significantly reduced the incidence of colorectal cancer.

 The disadvantages were that there were significant issues related to haemorrhage; so, you had to make sure that your patients had low risk of that. What was the other thing that those that were assessed in cardiovascular risk, which is the Framingham work as moderate risk, those people were also identified as being - would benefit as well. That was in [cardio] [unclear] so you could actually treat colorectal cancer, or prevent colorectal cancer and prevent cardiovascular disease as well, if you were using those assessments. So that was cholesterol and diabetes focus: age, systolic high blood pressure and [different] cholesterol levels, so you could work across from that [laughs].

 Interestingly, I used my - I use this calculator, and you can see that I’ve actually put the guidelines there. So, when I find someone in the 10 to 15 per cent risk category, in that age group of 50 to 59-year-old, I put 10 years; so, aspirin treatment, 10 years. Because that’s, I thought, oh well, if they can take it for two and a half, they can take it for 10, and I’ll be treating them for cardiovascular risk, maybe, as well. So that’s how I did it, so I have these…

Facilitator: So, you put this together? Or it came from…

Interviewee: Well this is the Framingham data, this is a cardio - this is one of the most useful visuals, I’m a visual person, I can’t remember numbers in tables, but I can remember visual patterns of things. So, this is a way that I say, well if I’m looking through here and I find someone in the green, then I’ll say, okay well you’re at 10 to 15 per cent. This is a really useful tool for patients too, because you can say, well if you - in cardiovascular risk, if you were to be in this group here and you were to lower your blood pressure down to there, then you’d go from that group to that group, which is halving your risk. And they say, oh that’s really - because that’s a really important thing for a patient.

 When you start raving on about five year CVD risk, they glaze over, but if you show them that you can go from the green down to there, and I say, well if you lower your blood pressure even more it wouldn’t make any difference, but if you lowered your cholesterol, you’d actually come down to this risk. It’s a really useful tool, to say, you can go from there to there to there, just by doing these things. They go, whoa, so, I’ll take my blood pressure pills, I’ll get my cholesterol lower and I’ll - what else can I do? I can’t get younger.

[Laughter]

 And by the way, did you know that if you took a hundred milligrams of aspirin, it could reduce your risk of colorectal cancer. They go, oh wow, and might be beneficial, however we have to do some checkpoints. So, these are the sorts of things that we are using for patients, and the 45 to 49 checklist. We also get people that are in this cusp; so, we’re seeing them at their 49 and we’re doing their cholesterols and we’re saying, in the next year or so, this is what we’d both be looking at.

 But of course that’s not the only one; we’ve got patients that have got - this is not just about population studies, you’ve got to look after people that have got high risk as a family history, of course, and those with the polyposis, congenital polyposis, familial polyposis, they’ve got a very high risk. People that - and I think, people that smoke and drink have got a high risk as well, so I’d be having a low threshold for doing a colonoscopy in that group 10 years before the first degree relative had a diagnosis of colorectal cancer. Or if there was an unknown history, I’d still investigate them, because I don’t think it’s fair to say, just because we don’t know who your parents are, therefore we can just assume that you’re ok.

 So, you screen people with an unknown family history just to be sure, and you never know, you can find these serrated adenomas and they’ve got a high risk of converting the other polyps. So, it all sort of happens around the 50-year-old for me, except for people that have got it in a younger group. I had a lady who was diagnosed when she was 27; was just thinking about her the other day - we were talking about it yesterday actually.

Facilitator: She was 27 and diagnosed with bowel cancer?

Interviewee: She came in here and just said, I feel unwell, I feel like I’m constipated, and I felt her stomach and she’s got this mass. So, I sent her off for immediate therapy, of course, at Peter Mac [unclear] and all those sorts of things, and she was - and I didn’t expect to see her again, to be honest. Anyway, she came in about five years later and said, hi, do you remember me? And I go, [laughs] like, yes, meaning, you’re still alive. I couldn’t help but saying that. She says yeah, pretty amazing, isn’t it? So, I think that’s pretty impressive, so you do get - that’s not about what we’re talking about today…

Facilitator: Yeah, that’s a bit…

Interviewee: But what I would do - and she would have known this already, because she would have had familial cancer screening, she would have her oncogenes tested and then genetic counselling. So, I didn’t go through all that with her, but I would if - yeah I just sort of refresh her mind that, when you have a family, make sure they all know about da, da, la, la, la, do you have any siblings, da, da, la, la, la. [You have first degree to] your parents should know about this, da, da, la, la, la. So, yeah, that’s what I understand. Is that the long answer? [Laughs]

Facilitator: Hey I’m happy with that.

[Laughter]

Interviewee: Sorry.

Facilitator: That’s okay. I’ll show you - we have a little summary of the guidelines.

Interviewee: Yep.

Facilitator: If there’s anything on there that stands out to you, you want to just mention it, or talk about it - something that you didn’t know even.

Interviewee: Yeah, now that I’ve seen it. Yeah so there’s a two and a half, which was confusing to me, the research. So, then there was a 10 year - so I think when I’m remembering the data, it’s to do with the bit about, yeah, they have to be expected to live 10 years, otherwise there’s not much point. So, I think that’s, when I was reading them, I - there’s too many numbers in there, I get one of them mixed up. So, I’ve got it clear now, that’s great. Lynch syndrome, yeah, well that’s a good idea, that’s rare…

Facilitator: Which is?

Interviewee: Lynch syndrome.

Facilitator: Oh, it is rare.

Interviewee: Yeah. Ah. Well, I didn’t know 600 milligrams was recommended, but I don’t think there were any studies that showed that a 100 was - because it just inhibits [cyclooxygenase] and reduces the transformation of the [lipids] doesn’t it. So 75 probably works just as well as a 100. Three hundred is just like hitting an ant with a mallet.

[Laughter]

 And you probably increase your risk of bleeding a bit too. Yeah that was - the people that have got those coagulation disorders, you’d be very careful with those [unclear]. So [make them do a HP] test, oh yeah, [then diastasis]. Yeah, the renal impairment, I think that’s a relative risk though isn’t it. I mean what [unclear] of renal impairment are you talking about. So that’s a bit obscure to me, so, does it mean that you don’t use it at all if they’ve got a eGFR of 50. So, yeah, it’s probably guidelines that they’re hard to implement when you’ve got those sort of broad statements. So, what I was thinking of doing is nailing the actual protocol. So, in terms of guidelines, I like flowcharts.

Facilitator: So, you know what to do in each situation?

Interviewee: Yeah, so you follow the flowchart, and it’s got branches and things like that. I think they’re much more useful, because you read this and realise you don’t need to know that, because it’s very rare. What you do need to know, is that and renal impairment. But you also need to know what degree of renal impairment. So, in your flowchart you’d say eGFR there, okay, eGFR there, not okay. Then you’d probably have a branch that says, well, if that person couldn’t be put on aspirin, then what else would you do? Would you stop them drinking, stop them smoking, and they’d probably leave your practice.

[Laughter]

Facilitator: They’ll find someone to say it’s okay.

Interviewee: Yeah, take the aspirin, and don’t worry about it.

[Laughter]

 Keep drinking, keep smoking, take some Somac or something like that. So, I think they’re the sorts of things general practitioners [unclear] guidelines, but in the end of the day you’re treating patients [laughs] and you say - they say, is this real? You say, yeah, it is, [unclear] guidelines. That’s about risk management, and you’ve got to then go down the rabbit hole of, what does that mean? Numbers needed to treat and those types of ideas. It would be nice to have that data. So, when my research tool that I was mentioning before - in the decision support process, these guidelines would be actually incorporated into the software.

Facilitator: Which is very nice, yeah.

Interviewee: Yeah, and so, once you drill down into it, it would actually say, what do you need to know? What’s the research? So, if people that already know this don’t need to read it. People that need to read something because they’re not sure, they only need what they need to know. But if you have to read the whole guidelines, like, uh, where’s the bit I really want to know? So, I think it’s a good start, but as a practical tool, I think guidelines have always been difficult to turn into action. It can take 12 years I think, is the average from a guideline becoming common practice, so…

Facilitator: That’s why I said new guidelines, right? [How long have they been around]?

[Laughter]

Interviewee: Yeah, that’s right, I think it’s been years they’ve been around, since the studies were done. But the new guidelines may be the ones that you printed on March 2019 [laughs].

Facilitator: Yeah, those were printed on that date, but they were released in 2017.

Interviewee: There you go.

Facilitator: Yeah, so we’re still saying, new guidelines [laughs].

Interviewee: Well that’s right, and we’ll be saying new guidelines for another 10 years, because that’s how long it takes to implement them across to best practice - to cross general practice. So that’s why the tool would be very useful. Anyway, there are things on there that I guess I didn’t know the detail, but as you can see, they’re probably low on my radar. So, my protocol would be, do you have a family history, how old are you, [blah, blah, blah]? So, you keep it into a very small little nutshell.

Facilitator: Yep.

Interviewee: Yep.

Facilitator: Okay, because you have mentioned the benefits and harms of it, and the risk. I know that you said you don’t like numbers, but…

Interviewee: Yeah.

Facilitator: This is an expected frequency tree that shows the incidence of mortality…

Interviewee: Yeah.

Facilitator: …of people who - men and women who are taking aspirin and [unclear], so the women are on the other side.

Interviewee: Yeah.

Facilitator: Maybe if you can tell me what you think about that diagram as well, that’d be great.

Interviewee: Well, in terms of patient education, or doctor’s education?

Facilitator: Either, it could be if you think it’s more beneficial for doctors, would you use something like that with patients? What would you change about it, if you could?

Interviewee: Well, one of the things that my research showed with [unclear] was that there are different levels of wisdom and understanding. You’re talking to a tertiary educated person that’s been on the earth for 40 years as a general practitioner. What I see is very different to what a patient sees. One of my teaching strategies is that the doctors - the patient says that, and the doctor hears this. But the other way around, the doctor says that, and the patient hears this. It’s totally different, and you ask them after a little while, now, how are you going with that, what do you understand that I’ve said? It’s quite excruciatingly painful that they say, well, you lost me in the first sentence [laughs], and you think, well, yeah, oh dear.

 Then you get - some patients take offense. You talk - they talk about you’re patronising them or talking down to them, or confusing them. So, I think, when you provide an educational resource that is designed to inform, my first impression is, it’s too busy, okay. It’s got too much information for purpose. So, if I was saying, well, what am I looking at it for, I’d go, 10,000 men, that’s the first thing I think, what’s that got to do with anything? The most prominent thing is the 10,000 men. When I read, I read a book backwards. I read the last paragraph in the book, and I read the first paragraph and then I read it backwards, and if I think it’s interesting, then I’ll read the book, okay.

 If I look at this, I look at, what are you trying to prove? So, to find the end result, I’m actually saying, what you’re trying to say is that there is a difference. That’s right down the bottom in these numbers that - then I’ve got to - because I’m a mathematician I’ve got to say, well, what’s that as a percentage? So, I’d say, well, is that - and what 10,000 are they? Ten thousand, is that only 100 men? Then I’ve got to think, well does that add that, plus that, does that add up to 10,000? Then my maths mathematical brain is going, this is too much for me to think about, what’s the point of this? Then I go up to the top and say, well, expecting frequency tree, expected frequency tree. So that would mean I’d have to know stats. So, frequency tree - expected frequency of what? Mortality, so that doesn’t actually mention bowel cancer. Oh, so now I’ve got to go down to here and I’ve got to say, oh this is about frequency of bowel cancer, heart attack, stroke, bleeding and death.

 So, this is a comparison of 10 years taking aspirin; and there you go, because the other thing said two and a half. Over 10 years of taking aspirin, so is that 10 years taking aspirin, or is that 10 years of people taking aspirin for at least five years? So, all of a sudden, now I’m analysing it and saying, this patient has, in that 10 years - so that’s the beginning of the study, end of the study. And in that group, there were people taking it for at least five years, in that group, and that was that age group. Then I’m thinking, why is it 50 to 70? Because the study was 50 to 59, so I’m thinking, what research is this about? So, I must not have read this research, so I’m thinking that.

 The next thing I’m thinking, okay what do I really need to know about this? Okay, well this is about side effects, this is about people that died in there for all other reasons. So, from all causes, that would include death from that, death from that, death from that, death from that, plus death from running over the road and getting run over by a car. So that’s probably right, well I could ignore that bit because that probably is far too much for me to think about. So, what’s the point of the document? So, it’s about the effects of aspirin on the incident events, so - oh that’s, so these are incidents. That’s a study where you’re comparing people that had aspirin, people that didn’t have aspirin, and you’re looking in that group, and somehow - what’s this number mean? Is that events? So, is that the number of cancers that occurred in that group?

Facilitator: Yep.

Interviewee: In that 10,000 men, so now I’m thinking, well that’s 10,000, that’s around about two per cent, if my mathematics is right. So, two per cent of those people, 10,000 had a cancer, and then they took the cancer 1.5 per cent. So, the number of people, the difference there is about 0.5 per cent, and that’s 44 cases. So, in those 10,000 men, 44,000, which is around about 0.4 per cent of a reduction. So, you’ve got to treat 10,000 men to save 44 people’s lives. That’s what I’m thinking that’s what that means. Now, I’m thinking, geez that’s a lot of aspirin for saving 44 cancers. Then I’m thinking, well is that reasonable? That’s a lot of people to treat.

 Then I’m thinking, righto, what’s the disadvantage? Well, 24 of them will have a stomach bleed, out of that. So, to save 44 lives, you’re going to have 24 people having a stomach bleed. The whole, in that group, death from all causes - so I’m sort of saying, well how can that be true? Because if you’re reducing that by 44 and that by 44 and that by five, how can you be only reducing the death from all causes by that? I’m sort of saying, well that should at least be 80, because if you’re reducing it by that and that, that makes, that should be a reduction of at least 80.

 So, to me, it’s very confusing. I would find this almost impossible to analyse, and I’m thinking, why am I reading it anyway? So that’s - and this is not a familiar style for me, so I wouldn’t look at this and say, I couldn’t read that. It’s not a - I didn’t learn these sorts of ideas. It’s graphically poor, I think. It’s not tabulated; if you’re going to have a table that says, so - and what does the arrow mean? It’s a green arrow; does this mean that that’s bad? I would imagine - so the arrows are supposed to mean that this is a good thing. So, reducing the death by 48, but I’m still sort of saying, well if that includes that, how can that be true? What I’m saying is that I’d look at this and go, not really interested in that.

 I see a lot of things like this from drug reps, and they show me their brochures all the time. You know what I do? I go, tell me what research paper this is based on. I read the research, because research papers are all written the right way. They’re all written logically, they’ve all got conclusions and some reason. They’ve also got things like [laughs] validity. They’ve also got references, so if you want to pick out something, like when you’re doing research on colorectal cancer, you might go, well what about these guidelines about the framing of the cardiovascular guidelines. So, you click on that, and that’s what I did there. I went to that and I went, oh, so I can put that on that, so I can simplify things.

 So, in general practice land, the things that we use have always got to be useful and functional. What’s happened in computer land is that it’s taken away our visual, logical reference library in our heads and put it onto a computer. So now if I wanted to look at my guidelines, I’ve got to go onto the computer and I’ve got to search to find the thing that I like looking at. So that’s where the study here showed that if you want to up skill people, you’ve got to have the stuff at people’s fingertips. A bit like a research paper, you flick on that and say, what are the guidelines, and then you go through that. If you’re not sure you can click on the Framingham work, it brings up the things. What do you want to see? You want to see a PDF? Yeah, okay, and you can bring them up to screen and you can talk to your patients.

 Otherwise you’ve got a room filled with educational aids and things. I wouldn’t - if I was doing something like this, I’d look at what I wanted to know first, and then I’d work backward. That’s why I read the last chapter of a book. I look at what the person’s trying to tell me, then I read the book in the context of what the book’s trying to say, rather than the other way around. Because it’s pretty annoying to have to journey through someone else’s mind, and then they tell you something, and you think, why didn’t they tell me that back there. I’m a really critical reader; I also review journals and literary style as well, so, yeah.

Facilitator: So, you would rather just go right to the research?

Interviewee: Well if I - no, not exactly that, I’d like to know what I want to know. So, in my head I ask myself a question, what do I want to know? The answer is, I want to know the justification for using aspirin. If I know the answer, that’s the end of it. So, I say, okay, now you’ve turned 50, I’ve noticed you’ve got a higher level of cardiovascular risk and now that you’ve had a colonoscopy, we know that you don’t have any other risk and you don’t have any other fa la la. So, I’d go - that’s the way I’d think. So, you go through the thingo and then you say, well, but you would benefit from aspirin. However, you’ve got to make sure that you’re not going to bleed, make sure you haven’t got a stomach ulcer, da, la, la, make sure your kidney functions.

 So that’s the way I think, it’s nothing like this at all. I think what you’re trying to do is just - sorry, I think what you’re trying to do is, how you engage people in thinking about new guidelines, how do you sell it. Is that what this is supposed to be about?

Facilitator: It’s more about what do GPs and other clinicians - because we are interviewing a lot of other clinicians - what do they know about them, and how do they find out about guidelines, how do they use them, what implementation barriers were there. Do they use decision aids, stuff like this. So, it was more about what you actually do, and your thought process, more than anything else. This is more exploratory so that we can inform maybe a future study on implementing guidelines. But we’d want to know how GPs and how clinicians would like that information. It’s more about what you think, than…

Interviewee: Yeah, well, I guess I may have over analysed that then, because I get down the rabbit hole.

Facilitator: That’s okay.

Interviewee: I don’t think this would help, because the one I showed you about cardiovascular risk is very helpful and on our software there’s actually a cardiovascular risk profile; you can actually plug in variables and you can actually see the risk go down. The patients like that because they can see the slider going down as you lower the cholesterol, as you lower the blood pressure, and that’s a very good selling point. Patients have to be sold to, they’ve got Facebook in their face, and they’ve got Google Doctor and they don’t expect you to just tell them stuff that’s complicated, they expect for you to tell them what they want to believe in. It’s a different world.

Facilitator: We are taking the same questions, or we are exploring this with patients as well.

Interviewee: Yeah.

Facilitator: That will happen next year. Right now, for this full year we’re focussing on clinicians and how they would like their information to be - new guidelines to be presented to them…

Interviewee: Yeah.

Facilitator: …and they will go to the patients as well. But we did show patients this expected frequency tree. About, over a hundred patients, and that’s where this expected frequency tree came from, because it was their most preferred way…

Interviewee: Yeah.

Facilitator: …of learning the information or being presented…

Interviewee: So, this is a patient aid?

Facilitator: Yeah, so we were saying, do you think you would use something like this with patients?

Interviewee: Oh, this is for a doctor to show a patient?

Facilitator: Yeah.

Interviewee: Right, okay.

Facilitator: But then over time, since I’ve been interviewing a lot of clinicians, they’ve told me, actually this is more useful for us, and we don’t think patients - especially all patients, they didn’t think that they would be interested in knowing the specific numbers and everything. So, they thought it would be helpful for them. So, then I reframed the question, and I said, would it be helpful for you, do you think it’s good for you, would you use it with patients, just to incorporate what other clinicians have said.

Interviewee: Yeah. Well, see there’s a whole range of the way doctors think, and they’ve all been taught differently, all learn differently, and they all have different strategies, they have different software. I think one of the hardest things with education of patient - of a cohort of very highly skilled intellectuals is that they will adapt if it’s on top of, or an extension of what they already do. I think adaptation is one of my favourite models of psychology - I teach psychology and treat patients as well. Adaption is a normal process of human experience, but if you try to adapt with too much of a jump between what you currently do and what you want the person to do, they’d struggle with it, and then they get disappointed, they get annoyed and frustrated, and that is the last thing you want, because they’ll disengage and they’ll see it just as a nuisance and they won’t use it.

 So, the most useful thing is to make sure that it’s useful for the patient and the doctor and at different levels. One of the focus groups - I can tell you this out of just in a general way - showed that, we were looking at whether what the patients experience would be when they saw the doctor looking at the research on the computer software, and it was showing a red light saying da la, la, la, la. What was the patient’s experience? Some of them said, well, I’d be very interested, and other ones would be saying I’d be very upset, because I don’t like things being abnormal. So that’s the simplicity of patient’s experience.

 If you translate to the doctor, what does the doctor try to do? The doctor tries to assimilate knowledge and get to the end result in the quickest way they can; this doesn’t do it for me at all. It’s too much information. What I actually want to do, I just want to decide if they need aspirin or not. Up here, I’d be going - this is a decision aid for patients who may need aspirin, full stop. Then if the doctor wants to read it, they read it. If they say, I know that bit, then they don’t read it. That’s what we call the adaptive technology.

 So, a doctor then will say, oh yeah, I didn’t - oh, that’s interesting, what is it about? It’s like me reading the back page. The back page says, this is our conclusion about whether you need aspirin or not. So, then I say, I need to know that, so I need to read the whole lot, or I’ll skim through it until I find the bits that I need to know. That’s the way we need to work, because doctors know a lot about a lot. If you want to change that behaviour you’ve got to give them some purpose and you’ve got to sort of integrate it.

 This doesn’t do it for me; I would have trouble remembering this. Then I’d say, well why would I use it? To help patients, they’d look at it and say, bleeding from the gut. So, they’d pick out the things - death. They’d actually read that and then they’d go back to, why does it say stroke? Why is it red? To me, when you’re doing an advertisement, you go on, what do people [show]. For instance, there’s the influenza bulletin. When you look at that influenza bulletin, what does your eye go to?

Facilitator: It goes to the spikes in the graph.

Interviewee: Exactly, that’s why I put it right in the middle. Then what’s the thing about the spikes that you see? What’s the thing that stands out as being different? The one that isn’t finished. They say, oh is that where we’re up to? I go, that’s exactly where we’re up to. Then the next thing I say, did you notice that it’s three times higher than the other lines? They go, yeah. I say, well that’s because we’re having the worst epidemic ever of flu. They go, whoa. Then you say, well, the last spike - see that one there, that was two years ago. They go, really? So, if you watch that line go up, it will actually be off the chart by the time we get to the end of August. They go, whoa. So, what can I do, doc? Here, have a flu shot.

 So, these are selling points, and the patients these days, you can’t just say, you need the flu shot, they’ll say, why? Or they’ll say, I’ve heard they give you the flu, or, I don’t have vaccines. So, I don’t even start with that. I say, oh what’s that, have you seen that on the wall? They go, oh yeah, what is that? See, you have to sell them something before you try and rationalise it, otherwise people these days, they say, but Facebook says it gives you autism. I go, okay, well, you have a think about it, but I’d go on this particular risk, and autism’s pretty rare, and you can’t get it. You have to actually - it’s an [early childhood] thing. Really? They have no idea; patients have no idea what’s going on. They’ve been given misinformation.

 I’m really pleased that the ACCC is coming down on Zuckerberg and Facebook and all those [unclear] things and they’re going to rein that in and stop this misinformation, because that’s half our battle, convincing doctors and convincing patients. All right, so the feedback is, yeah, I’d start again with that.

Facilitator: Okay, well thank you so much for your feedback. I’ll turn this off.

**END OF TRANSCRIPT**