**PH04**

I: So we’ll start kind of broad, if you could please tell me about the types of preventative healthcare that you do currently offer to patients?

P: like not on prescription? Like over the counter? Basically, we are mainly diabetes and aspirin as low dose for people with myocardial infarction after the surgery. I think that’s all hahhaa. Oh asthma we do, do a bit of asthma uhhh training for patients and how to use asthma and what the symptoms are and think that’s mainly, we are mainly doing asthma and diabetes is a major push in our pharmacies.

I: great, do you also do work with smoking cessation?

P: smoking cessation we find a special reason it don’t seem to be, over there, so successful, everybody out smoking already. [smoking cessation isn’t that successful]. So to us smoking cessation is not a big thing, like here and there we do get people ask for it, but we do not have a program, like for diabetes and asthma every second week we like have a day for people to come in we check their diabetes and how to use their Ventolin, those things.

I: could you tell me more about that?

P: like for diabetes usually we try to those people who are have a cardiovascular and overweight, we can see whether they have diabetes, if they have already diagnosed diabetes, we ask them to come back every month we get a blood test to see if they are doing well. But this is just a spot test, but we do recommend them to go back to see their GP every 6 months for the HP1C.

I: great well thank you, so if there are any what are sort of products that you would recommend for disease prevention?

P: mmm, mainly for diabetes there’s not much we are doing, its mainly for their diet control, and other thing. Not really medication. For asthma, we are more like Ventolin, that sort of thing. Like if they have been using a lot of Ventolin, we ask them to go back to see their GP to put on some steroid or something. So they may stay under control.

I: great, so further into that question, what are the factors that would influence you to recommend one preventative medicine over the other, such as cost, evidence, etc.

P: because of the area I am working in, cost is not really an issue for a lot of patients. Its more, like even though I always recommend the patient if they can afford it, some of the, even the like multi-vitamins, there’s not, a lot of them they don’t have much scientific proof, like for example vitamin c and all these things, but just, I always say if you can afford it and it doesn’t do you much harm, why not go on it.

I: great and what do you, what role do you think pharmacists play in preventative health?

P: pharmacists should be very active role I personally think. Because if you ask most of our patients the first line of health education, they come to us. Rather than go to the GP, one thing GP is overwhelmed with patients and don’t have time for them. But we do, and also, actually a lot of patients reckon we are, like we are more specialised in medication. GP they are more specialised in the other process.

I: great and what are your views about pharmacists playing an even bigger role?

P: I always thought pharmacists should be able to have a much bigger role and more collaboration with GP.

I: So bigger role and more collaboration?

P: yes

I: could you expand on that? How would…

P: like for example, it’s a very sensitive issue sometimes as you come into prescribing. Like especially, we have very close relationship with a group of GP across the road, they are fantastic GP, they always like sometime we have breakfast together, like he always reckon, his clinic prefer to be more into treating the patient, rather than a lot of, he see a lot of patient just come in for script, for example, their cholesterol script, so that, to him, I mean to them, its not really need them to write a script. He’s just coming in, and both of them just sit there for 5-10 minutes and go. He prefers to like, treat difficult cases, like if diabetes not under control, high blood pressure not under control, that’s what he say like as a pharmacist. At the moment he’s using a lot of his nurses, so the nurses will do a lot of things, like to write, not really, but he will just put an authorise, authorise [talking about the scripts] so I would thing that pharmacists would be more into that role to be more collaboration with the doctor. So the doctor can be more concentrated on how to treat the patient. yeah

I: great thank you, so how do you keep up to date with new drugs and clinical guidelines?

P: because we are, some of them are through the rep, a lot of them is journal, like uhh I do recommend, its just recommendation, not a guideline for my staff, but all the pharmacists should at least 1-2 hors reading the journals. So what we do is like, because our pharmacy work very long hours, so we overlap 1 or 2 hours so I always ask the second pharmacist to come in earlier like for today if you come in early, you let the pharmacist have an hour so just read through all the article and the next day is your turn. And also we, when the journal come in, I usually write down the initials so every pharmacist should have taken it. But its not a guideline, it’s their choice I think. yep

I: great thank you, do you attend any conferences or anything?

P: not conference, but what do you call, continued education from the pharmacy college.

I: yep, and the CPD points, how do most of your staff and you like to…

P: some of the, mostly for me, I don’t know how the CPD point for my staff, for me usually I go online, and then some of them is the conference, some of them is the uhh continued education.

I: do you find online to be…

P: I find online is much easier, because when you go to the lectures, sometimes because most of them are 7 o clock, it can be quite tiring hahaha, you tend to fall asleep very easily. But online is good because you can do it anytime you like. And I do find it quite helpful most of the online.

I: great thank you, and when you do look at them online, what avenues are you using?

P: uhh in what way?

I: for the CPD points.

P: because most of them, I usually go through the pharmacy guild. Pharmacy guild, they have all different type of like programs you can, then you can choose what. Like I’m more into, I usually don’t go onto those like, not new drug, like uhh, I’m more on the preventive medicine. Like if they have something on how to recommend patients and how to deal with patients, those things, that’s what I usually go on.

I: thank you. So when there is a change in the guidelines or recommendations, how do you normally find out about them?

P: usually through the board. The Pharmacy Board.

I: and what do you think are the challenges you have with keeping up to date?

P: time, especially uhh, like I do work very long hours, I work about 58 hours a week, so I think time is the issue.

I: and keeping up to date with new guidelines, same issue?

P: yeah it is, yeah

I: thank you, so are you aware of the new cancer council guidelines? Have you come across them at all?

P: the council, no, like most of it, because we don’t get on that website very easily yeah.

I: great that’s absolutely fine, I have a summary sheet actually, if you’d like to go through it. Just because we are recording, if I could get you to think out loud, so while you are reading if anything pops to mind just say it out loud.

P: OK

I: great thank you

P: yep but most of uhh, to me 50-70 years old, that looks very young. Like most of my patient is already on low-dose aspirin once they are on like, when they have myocardial infarction incidence. So, I think one interesting part is especially when it comes to low-dose aspirin, there’s always issue about the stroke. Whether it is due to blood too thin or blood too thick. So, like, like just yesterday a patient came in he just came out of the hospital and just had a bypass. And the doctor put him on aspirin, and he heard about like his friend actually, because of aspirin caused a stroke. So that’s why he’s asking me about that. To me I think its always an issue about like if you are constantly taking aspirin, whether there’s the issue of thinning the blood too much. So there’s always like when you recommend people take low-dose aspirin its always at the back of my mind, whether should it be or… hahahha. Or yeah.

I: so do you receive a lot of feedback from patients about their aspirin use?

P: I don’t really get a lot of feedback, whether, because a lot of the time if they have a stroke I usually don’t really. Yeah actually I should, I never really ask them what causing the stroke. yeah, Yeah actually next time I will ask them if they have like incident of myocardial infarction or stroke, I will ask them if they were on aspirin before. Hahaha, see whether it is. But like nowadays, actually we see a switch, a big switch from aspirin to the newer drug Eliquis. I’m not sure if you realise that. Yeah it’s a newer drug supposed to be less side effects.

I: could you tell me a little about it?

P: yeah it’s actually, it’s also a blood thinning but it’s for indication for people who have ulcer problem, because it doesn’t really affect the gastric thing. But I’m not sure if it does help regarding the colon cancer

I: so has this been recommended after myocardial infarction?

P: yeah actually a lot of my patients are switching from aspirin to Eliquis. I’m not sure whether it is the gastric issue or sometimes GP is put under pressure, like for example if your friend is on aspirin with a lot of side effects and say “the doctor change me to Eliquis!” so they talk to their friend, their friend say oh I’ll go back and tell the GP I want Eliquis. So like, recently, I would think we got about 50-50 switch. Like we hardly use any Eliquis and suddenly last 6 months we have about 120% increase of Eliquis. And there’s a big drop in low-dose aspirin.

I: thank you, so have you heard anything about this one [CCA summary] at all?

P: this one [CCA summary] yeah, I think about 5 years ago I saw a paper, they were talking about it and recently it seems to be more pushed ahead for this. Yeah.

I: so what in your opinion are the potential benefits and harms?

P: the harm is that the blood is too thin, may cause stroke [likely referencing haemorrhagic stroke]. benefit, I umm, well as I mentioned before they, I see a report, they say 40% drop in colorectal cancer which is significant. Soo yeah and aspirin is pretty cheap drug, yeah I can easily recommend it but it seems like there’s a massive [age range], because from 50-70, most of my clients are 50-70 hahaha.

I: yeah great, so do you have any additional views about low-dose aspirin in general as a preventative medicine?

P: no actually, aspirin is, I do think aspirin is a very good drug even though a lot of bad things about ulcer and all those things, I think if you use it properly I think it is a much better drug to me than paracetamol.

I: by properly, what do you mean?

P: like if you take it accordingly to the dose rather than you have headache, take 2, and doesn’t work take then another 2, hahaha.

I: so have you noticed its well tolerated or?

P: actually yeah I find low-dose aspirin even 300mg, I don’t see any issue, most patient come back. Because I always ask them when they take aspirin, oh do you have ulcer, they always say, no I don’t, it seems to be doing well.

I: thank you. So how receptive do you think your patients would feel about using aspirin to prevent, uhh lower their risk of colorectal cancer?

P: that one, probably because there’s not much advertising outside, so like even the anti-cancer they talk about more the tests [regarding poo test] than using the aspirin. So I don’t know, I think if we say a lot of time, because most of my patient are much older patient, they do still have this imprint in their brain that they would like to ask their doctor first. If they have never heard of it and we recommend it.

I: so you think they would need initiation from their doctor?

P: yeah I do think so. Yes yep. Or for example if the anti-cancer council can put a lot of ad sort of promoting it on TV, people have heard of it then they will come to the pharmacy and we can tell them more about what it is.

I: so you increase awareness so that they can initiate the conversation.

P: yes yep, yeah. Because sometime especially for older patient, I do think if we generate the conversation they, they seem to think is it because of really clinical data or is the girl just want to sell them more?

I: do you think that would be an issue with aspirin?

P: I don’t think there will be aspirin at all, because with the older generation constantly using aspirin. It’s the younger generation that has this impression that aspirin is dangerous. That’s why they opt for paracetamol.

I: great thank you. So what do you think are the barriers to pharmacists counselling patients aged 50-70 about using aspirin to prevent colorectal cancer?

P: I think, I don’t see any barriers, but sometime its very hard to come out the subjects [difficult to initiate conversation] like for example if they come for cold and flu, and you say oh you are over 50, should I recommend you to take aspirin hahaha, it just, I find it, personally I find it very hard to initiate the conversation, unless like some of my regular we really talk about them, then we can start up the conversation. I suggest that patient coming in for a certain thing, its very hard to generate the conversation, for example if the, if the awareness is there, we can put it like, diabetes awareness week for us, so the patient can come in when we can discuss about colorectal cancer that type of thing.

I: great thank you, so do you have any ideas of how we can overcome those barriers? So you said the main issue was initiating the conversation?

P: yes, yes, well as I said I think if there is awareness there, then we can generate like a certain week for people to come in, but colorectal cancer is very hard, not like diabetes, you can really test it, don’t know actually. Pamphlet may help, to generate, I think the easiest is to generate awareness from the patient point of view, then they will come and ask us. Give them some sort of curiosity and they will come and ask us more about it. Or ask their GP more about it and the GP can refer back to us. Yep.

I: do you think they’d have problems using the aspirin?

P: I don’t think they’d have problem using aspirin, because low dose aspirin is just one tablet. Don’t make much difference. Yeh.

I: great, so do you think using these guidelines [regarding summary sheet] would help you discuss with patients the benefits and harms and help you initiate the conversation maybe?

P: I don’t think it will help, yeah.

I: why do you think that?

P:because as I said, its very hard to generate a conversation and also colon cancer tends to be taboo thing, but doesn’t really like to talk about it, not like breast, its just so much on awareness, everybody knows, colon cancer is not really…

I: great, so we have made some graphics to help communicate the risks and harms to both pharmacists and patients themselves. Same task as before, if I could get you to think out loud as you go through it that would be great.

P: so this chart is to help us to show to the patient or?

I: both, so it is still in development but any use.

P: like to show to patients whether they are aware of this is it?

I: yep, so to communicate the risks and harms to patients.

P: mmm, I think the highlighted one that patients know pretty well, yeah I should think that would work very well. If you printed out like a pamphlet, it may help, because most of our patients they tend to, I’ll put it in their paper bag and they tend to look for these things inside their paper bag.

I: would you add a pamphlet with this? [ re EFT]

P: yes yes, yeah, it seems like yeah, it looks very significant. The women doesn’t seem to have… doesn’t change that much huh. Yep I think it will help. yeah

I: thank you, so that’s actually the bulk of the questions, are there any comments you’d like to add about anything at all?

P:no no. as I say, more awareness is needed, to be aware, the community needs to be aware of what’s going on rather than for us to generate that, and also because sometimes we can be quite busy.

I: great, any questions you think I should add to this interview schedule to get more answers or anything?

P: actually it’s a good idea to also, like you are targeting to pharmacists, how about the pharmacy assistants?

I: pharmacy assistants?

P: yeah they may also need, because it’s a very good if the pharmacy assistant is involved, they generate the interest. Like last week, one of my staff, uhh, because I did like once I month I sit down with the staff and go through what it is, so last month we did diabetes and what are the potential risks of patients. Like last week we got a patient coming in he’s got high blood pressure, high cholesterol, so the first, one of my pharmacy assistants say oh have you recently had a chat, because he is also a little bit overweight [regarding the patient], because we talk about the risk factor and he saw this, and then she did ask the patient, and the patient said no not really, so actually she recommend him talk to us so we sit down and go through like all the risk about, like the potential risk of diabetes, losing weight and all those things. And we did do a blood sugar test straight away for him, his is eight point something so he is on the high side. So I do think if the pharmacists assistant is involved it will be much better.

I: so you think expanding the role of the pharmacy assistant?

P: yeah it is, because for them, because a lot of the time, the pharmacy assistant tend to talk a lot with the patient, so a lot of patient sometimes it’s more comfortable to talk to them, but not as advice but as to initiate conversation.

I: great thank you so much for that. I’ll turn this off.

**Field Notes**