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**START OF TRANSCRIPT**

Facilitator: Just this clinic. Okay. So have you heard about the low dose aspirin guidelines to prevent bowel cancer?

Interviewee: So are these specific Australian guidelines?

Facilitator: Mm.

Interviewee: No, I have not.

Facilitator: No? So I’ll go ahead and show you. We’ve come up with a little summary sheet of the guidelines and if you could just do like a think out loud.

Interviewee: Right.

Facilitator: Of your first impressions of them as well.

Interviewee: As guidelines? Or in terms of usefulness? Or in terms of evidence and believability and all that stuff?

Facilitator: All of that. Yep.

Interviewee: So I can tell you now that I did about 15 or 20 minutes of research last night on this topic.

Facilitator: Okay.

Interviewee: And it struck me that from the bit that I read, that the evidence for aspirin in colorectal cancer prevention is really, really poor. That is to say, there appears to be a real benefit, but the degree of benefit is very small and the length of duration of treatment to obtain a meaningful benefit is very, very small and all the benefits that I could see referred to preventing incidents of cancer, not death from cancer and given that colorectal cancer and oh, and also that most of the research seems to have been done prior to fairly universal screening.

 So given that we now have a pretty robust, albeit not completely accepted screening methodology for detecting cancer in the early stages, the utility of aspirin to prevent cancer death as opposed to prevent cancer, seemed to me to be very small without actually reading all the numbers through it.

Facilitator: Okay.

Interviewee: So with that as the background, I will now look at the piece of paper in front of me.

Facilitator: Okay.

Interviewee: All right, aspirin should be actively considered. Yes, that is true. In those at risk of CRC, it should be actively considered to prevent colorectal cancer in for people who are at average risk. Prove it. A low dose is recommended for at least 2.5 years. Benefits of cancer prevention is evident only after 10 years. So life expectancy should be considered. Absolutely. Recommendations for those at high risk. Well that’s a completely different category. Those with Lynch syndrome should be advised to be given aspirin when they begin colonoscopy screening. Well that’s fine. That won’t be by me.

 Non-syndromic family cancer patient should be actively considered. Maybe. 600 milligrams per day has shown to be effective but lower doses maybe as effective and is recommended. Well that’s just nonsense. To say lower doses maybe effective and that’s what’s recommended, doesn’t make any sense at all. Either you don’t recommend something that might be effective. You recommend something that is shown to be effective, otherwise what’s the point of recommending it?

 Purely because I do a lot of proof reading, if we’re using upper case, upper case, upper case, upper case, lower case, lower case that doesn’t make sense.

Facilitator: Okay.

Interviewee: That’s me being really painful. Do you want me to be painful and point out things like that? Or not?

Facilitator: Yes, point out anything that comes across. It’s helpful actually.

Interviewee: Okay. Aspirin should be avoided for those with uncontrolled hypertension. Why? I mean, presumably because of the risk of cerebral haemorrhage. On the other hand, well okay. Helicobacter can also be constituted. Should be avoided for those with Helicobacter pylori. So that sentence doesn’t make grammatical sense. Aspirin should be avoided in those with Helicobacter pylori can also be considered.

Facilitator: Okay.

Interviewee: It actually doesn’t make sense as a sentence. Helicobacter pylori can also be considered. I think what they’re trying to say…

Facilitator: So that can also be considered but can be removed. Right?

Interviewee: Aspirin should be avoided in those with Helicobacter pylori as toxic, yes correct.

Facilitator: Yep.

Interviewee: As toxicity from aspirin is enhanced. Right. Aspirin should be avoided in those with current dyspepsia. Yes. Ulcer aspirin allergy. Der. Bleeding diathesis in increased risk of gastrointestinal haemorrhage. Yes or renal impairment. Fine and that’s it. Okay.

Facilitator: Yes.

Interviewee: What this doesn’t tell me that I want to know is, where’s the benefit? And the other part of course, is the difference between general practice and the rest of the universe, is that we try to think of big picture and to a man with a hammer, everything looks like a nail and to a researcher and aspirin and colorectal cancer, that’s all you think about. But really the question is, I mean what is the point in giving somebody, in preventing their colorectal cancer if you’re increasing their risk of dying of a haemorrhagic stroke. Okay, you talk about that. But on the flipside, where’s the interplay between cardio-vascular prevention due to aspirin and CRC prevention due to aspirin and that’s really the question.

Facilitator: I’ll show you this expected frequency tree there.

Interviewee: Ah okay. Expected frequency tree.

Facilitator: That’s what I think you’re looking for, right?

Interviewee: Let’s have a look at this, okay. Expected frequency tree. Show me the effective aspirin on the incidents and events over 10 years. 10 years of taking aspirin. Comma, over 10 years of taking aspirin, or at least five years, comma in Australian men or women aged 50 to 70 years. 10,000 women, 10,000 men had bowel cancer, heart attack, stroke, bleeding, no aspirin. Why do we men suffer so much?

Facilitator: Don’t know.

Interviewee: All right. So fundamentally what you’re saying is if we give 50,000 year’s worth of aspirin, we prevent somewhere between 20 and 30 cases of cancer. So, if I say to you, you need to take this tablet for 2,500 years to prevent a case of bowel cancer or you need to take this tablet for five years to prevent one in 500 hundred cases of cancer. That’s effectively what we’re saying. So if I give you a tablet and I say to you that here’s a tablet, there’s a 499 out of 500 chance that this tablet will make no difference to preventing bowel cancer, what proportion of patients do you think are going to take a tablet every day for five years?

Facilitator: Well that’s what I want to know from you.

Interviewee: I think it’s, there are so many better health messages that I could be sending to patients in terms of where I need to spend the 60 seconds that I have to preventative medicine with patients. You know, how many people do I have to get to stop smoking to have and this is not to save lives, this is purely to prevent a cancer. Which probably won’t kill them anyway, right? Yeah, chances are most people with bowel cancer survive, agree?

Facilitator: Some do.

Interviewee: Most do. The vast majority of people with bowel cancer survive. Because it’s usually picked up early enough and cancer’s a, bowel cancer is a curable condition, particularly if you’re already at the age from 50 to 70, you’re already doing FOBT screening. So I’m not saying it’s fun to go through bowel cancer surgery and follow up therapy. I’m not saying it isn’t better to prevent them to treat. Of course, it’s better, but if you’re actually saying to a patient, look this has got a one in 500 hundred chance of preventing bowel cancer in you and the bowel cancer probably wouldn’t kill you anyway.

 So let’s say, you know if I remember correctly, it’s something like 70 or 80 per cent of bowel cancers, if you’re going from a stage one to a six, a to d.

Facilitator: Yep, it’s very curable in the early stages.

Interviewee: Correct. It’s 95 per cent dukes a. 80 per cent dukes b. 60 per cent c and 25 per cent d, if I remember correctly. So you’ve got at most, the benefit is preventing one in a thousand deaths. Why aren’t I spending that 60 sixty seconds saying you know, stop smoking. Eat better. Exercise more. Do some relaxation. Put on your seat belt when you go for a drive. It just seems to me, you know, yes there are statistical benefits, but in terms of pragmatic day to day benefit, is this particularly useful? I don’t think so.

 Now we can add up the other issues as well. I suppose if we add in heart attack. We were part of the ASPREE trial and ASPREE was you know, very interesting and one of the few bits of research that we’ve agreed to take part in, because we actually thought it was a useful question and a well-designed trial and ASPREE sadly showed, as you probably know…

Facilitator: Yep.

Interviewee: That it did nothing. You know, so we’ve got minimal improvement in heart attack in the 50- to 70-year-olds. Having said that, I’m now on aspirin by the way.

Facilitator: Okay. Is that for primary prevention?

Interviewee: Cardio. Don’t say primary prevention. You’re not a GP. You don’t understand primary prevention.

Facilitator: I don’t know.

Interviewee: Okay. Primary prevention as used by specialists, means take cholesterol tables to avoid a heart attack. Primary prevention is used by GPs means get a vaccination. It’s got nothing to do with modifying risk factors. It’s got to do with way earlier in the prevention chain.

Facilitator: Okay.

Interviewee: So when I yell, I’m not yelling at you, I’m yelling at my, because of my frustration at poor language in the world at large. Okay. So I’m not at all overwhelmed by any of this. I’m mildly reassured by the relatively low incidence of side effects from it, which is nice. I note however, that you somewhat cheat by merging stroke into a single category instead of…

Facilitator: Haemorrhagic.

Interviewee: Haemorrhagic and ischemic. Which I think is probably appropriately split up in these circumstances.

Facilitator: And what other feedback do you have on…

Interviewee: On that chart?

Facilitator: Yeah.

Interviewee: No, I think it’s a useful chart. I think that…

Facilitator: Do you think it would be beneficial to you know, speaking to your patients about aspirin and the benefits and harms?

Interviewee: From a practical point of view, I could have 250 charts on my desk. For breast cancer and for prostate cancer and for the role of cholesterol. Charts are not that useful for showing patients, because I’m usually not going to show it to them and the proportion of patients who actually want to see hard numbers, is incredibly small. Now [Roval] is actually a fairly health-literate area and they’re not that interested in…

Facilitator: In the hard numbers.

Interviewee: In going through something like this because it’s just, you know. So I think it might be useful to have this as you know, on my computer and I can access it and pull it up if I need to. Yeah, it would be useful for a small proportion of patients, but fundamentally what they’re going to want to know is, what do I recommend and the order of magnitude of usefulness of it. Okay.

Facilitator: Okay. What do you think about, or what are your opinions on using low dose aspirin for more higher risk patients?

Interviewee: So the Lynch syndrome patients?

Facilitator: Mm-hm.

Interviewee: So the little bit that I know about that and it is very, very little, is it probably is a very good idea, but given that those patients are going to be managed by the specialists rather than me, that’s probably appropriate, you need to be talking to the geneticists and the gastroenterologists.

Facilitator: Yeah and they’re a part of this trial as well.

Interviewee: Sure. So the answer is yeah, if the recommendation comes out and it's clear and I presume if numbers are significantly more impressive, than that makes far more sense.

Facilitator: Yep. Okay. All right, so what do you currently recommend in terms of prevention for patients?

Interviewee: For bowel cancer?

Facilitator: Yeah for bowel cancer.

Interviewee: So I would primarily recommend a high fibre diet. Adequate water and exercise. I would recommend that they do their FOBTs. It took me a long time to get convinced about the value of FOBT and slight degree, I’m still not completely convinced, but pretty much convinced of that particularly on a repeated basis and the real issue, the difficulty I find with bowel cancer, is really the question of who should get colonoscopies and how often. You know, depending on who you speak to, there’s private insurance in the United States, everyone gets a scope at 40 and then every, two, three or five years after that and that’s clearly overkill. On the other hand, should everybody get a single scope at some age to assess - there is probably, doesn’t make a lot of difference what a scope every 10 years be useful, compared to FOBTs, it’s probably too long an interval. Yeah, probably scoping is not a great…

Facilitator: It’s not very clear.

Interviewee: It’s not a - no, no, it’s not a cost effective and useful screening tool, but if you’ve got one first degree relative with bowel cancer, is that enough to need a scope at index age minus 10? That’s certainly what I do at the moment. How often should that be repeated? I suspect the frequency of repetition depends on the stage of the mortgage of the gastroenterologist, two years, three years, five years. I see different recommendations come from different gastroenterologists. So I suspect there is no clear consensus.

 Of course, the other issue in all of this is the fundamental law that guidelines are very useful at telling you what to do for 10,000 patients. They are useless for telling you what to do with the person who is in front of you. So one of my concerns about this notion of implementation is that it becomes a little bit of a battle of if GPs aren’t following guidelines, they don’t know what they’re doing. Whereas the GPs would say, you don’t know what we’re doing because you only know what the guidelines have shown for populations, but not for individuals.

Facilitator: Right.

Interviewee: And so with, GPs cop a big pounding in the press regularly about not following guidelines and these are guidelines, not the 10 commandments and it’s a worry when academics seem to think if the rate of x, y and z doesn’t match their predicted model, that that means there is a problem. Whereas in fact most studies aren’t actually done on GP populations anyway because the exclusion criteria are the longest part of the documentation. So if you’re ruling out half the patients that we see, why would we follow the guidelines?

Facilitator: Right.

Interviewee: Okay am I sounding like a grumpy old man?

Facilitator: No, I think you’ve been giving very good information and I’m happy that you’re elaborating. So that’s great for research.

Interviewee: Excellent.

Facilitator: We need to know this.

Interviewee: Okay.

Facilitator: So how do you think patients will respond if they hear of this recommendation, or active consider it, if they hear that?

Interviewee: From you, or from me?

Facilitator: From you. Or from a GP.

Interviewee: No, I think if we recommended it, there would be a good chunk of patients who would think about it and it really just depends on how hard you sell it. So y, if I really want to convince somebody to take a statin, I’ll succeed eight or nine times out of 10. If I want to talk somebody out of statin, I’ll succeed nine or 10 times out of 10. If I have an open-ended shared decision-making discussion with a patient, then, it will be somewhere in between and of course that’s again, this notion will end up being, GPs are under prescribing aspirin. Well, you don’t know whether GPs are under recommending aspirin; you don’t research patient’s responsiveness to it. To the advice, let alone compliance, which we’re not allowed to call compliance, meant to call concordance.

Facilitator: Okay. So have you had any feedback from any patients about their experience taking aspirin?

Interviewee: For colorectal? No.

Facilitator: Or just in general. Even if it’s...

Interviewee: Yeah, they hate it.

Facilitator: Oh they hate it.

Interviewee: [Unclear].

Facilitator: Why is that?

Interviewee: Well, nobody loves taking aspirin. Because what’s the upside of taking aspirin? You may or may not be preventing something at some point in the future and you will never know whether or not you prevented it. So the only response you could ever get from somebody for taking aspirin is I’m bleeding. I’m bruising. I have indigestion. I have a stomach ulcer or I’ve had a stroke. You can never have anybody say I’m so glad that I’m on aspirin. All right? So you’re hiding to nothing by recommending it. You’re never going to get thanks for recommending aspirin.

Facilitator: Yeah and have you come across those?

Interviewee: And there’s no marker. So at least if you give somebody a statin, you can at least show them, look your lipids have fallen and I can demonstrate to you in your particular case how much your cardiovascular risk has declined. I will never be able to give somebody individual, their individual benefit from taking aspirin. I can give them a global figure, but I don’t know if that applies to them or not.

Facilitator: Is that the population level like you’ve been saying? Yep.

Interviewee: Correct, yep. Whereas with statins I can give it on an individual level.

Facilitator: So do you currently recommend those?

Interviewee: Statins?

Facilitator: Yeah.

Interviewee: Well, on circumstances, yes.

Facilitator: Yeah, it depends on the patient.

Interviewee: Sure.

Facilitator: Yep, okay. So generally, when there is a new guideline, how do you find out about it?

Interviewee: Guidelines?

Facilitator: Yeah. Like what’s your…

Interviewee: Journals. Medical Press. Conferences. Letters from specialists. Meetings, et cetera.

Facilitator: A lot of different avenues.

Interviewee: Sure.

Facilitator: Okay and how do you go about incorporating a new guideline that you found might be useful, into practice? When you’re sitting here with a patient.

Interviewee: I don’t incorporate guidelines. I think that’s a really bad construct. Guidelines are not there to be incorporated into practice. Guidelines are there to inform my decision making, so I have a discussion with a patient about what may or may not benefit them. But that’s not the same as guidelines guiding my practice or being incorporated in my practice. It’s no different to me reading the product information of a new medication. It’s part of my overall education. So yep. I don’t think that I incorporate guidelines. I incorporate the concepts and thoughts that the guidelines teach me about, but the guidelines never inform my practice, because my practice is on the individual level, not the population level.

Facilitator: Right. Okay. All right. In earlier, you did mention that it took you a long time to be convinced of the FOBT and the evidence behind that and using that versus colonoscopy…

Interviewee: Well, I wasn’t so much against the colonoscopy. Look, the whole notion of preventative medicine - there was a very interesting article written by a Swedish doctor some time ago saying is preventative medicine ethically justifiable? So there is an inbuilt assumption that we should be doing everything that we possibly can to improve patients health, okay, and the question actually is why? Because patients don’t actually always want their health to be improved. If they did, we wouldn’t need to run public health campaigns.

 People would be doing it already and whenever you inform somebody that you could be doing things better, what you’re really doing is generating anxiety that what you’re doing now is not good enough. It is impossible to say to somebody, look you need to get a mammogram because it could find a breast cancer really early. What, I might have breast cancer? Yeah, but this will find it early and it will make treatment so much quicker and easier and more effective. But I could die, couldn’t I?

 Now are you actually, you don’t weigh that. I don’t believe you, in the research setting collective sense weigh that up. There’s just an inbuilt assumption that people want to live longer and live healthier and of course that’s generally true, but not always. What was the question?

Facilitator: I think I even forgot the question. It was around guidelines but then moving towards yeah, oh the FOBT.

Interviewee: So I first heard about FOBT from, I can’t remember his first name. St James, he was at Melbourne Uni and Royal Melbourne Hospital, head of gastro there and he was talking about FOBT on a regular, as a screening too. I reckon I heard this in the…

Facilitator: Paul James?

Interviewee: Paul St James maybe?

Facilitator: Yeah.

Interviewee: Yeah, maybe. It was in the late '80s, early '90s and the notion of doing preventative screening was relatively uncommon. We did pap smears and chest x-rays for TB had already been discarded as being unsafe and useless and so, he was really keen on FOBT and it was, oh it’s messy and slow and what’s the acceptability and how useful is it really going to be? But gradually the evidence for it convinced me that it does have a place and a role. So I’m open to being, I try - GPs are on the one hand accused of being far too gullible and taking new drugs on at face value and we shouldn’t see drug reps because all they’ll do is convince us to do things that aren’t proper and I know we’re told that we’re too slow to take up guidelines and advances in clinical care, well, which is a guise.

 Are we that stupid that we only pick up the bad and never pick up the good?

Facilitator: And when it comes to your own practice, would you say that you’re an earlier doctor or?

Interviewee: No. I’m a later doctor and the reason I’m a later doctor is that there are very few things in medicine that are quantumly better than what was there before. There are very few game changers in medicine and there are far, far more oops, we over-reached and we’re going to take this drug off the market and this test isn’t anywhere near as good and reversal of guidelines then there are, this really is correct and we should have done this 20 or 30 years ago. .

Facilitator: Okay, so always been, have you always been a later doctor? Yeah.

Interviewee: Oh, well, one of my golden rules is that which you learn in your youth, both good and bad stays imprinted. So, I guess what I learnt when I was a medical student in my first two, three, four, five years out, whether it was new or old, was to me, I took as being correct and so whether it was, I don’t know if I was being an earlier doctor or not, I just took it on that’s the standard of practice and then everything that’s come on since then, I’ve seen through the prism of, well, is that really better than what I’ve always done.

Facilitator: Right.

Interviewee: So I’m now turning into one of those Luddite intransigent doctors that I used to mock when I was a young doctor and why are they still prescribing BTZ when they should be prescribing something safer.

Facilitator: Okay, well that is the end of the interview. I’ll stop this.

**END OF TRANSCRIPT**