**PH07**

I: So if you could first of all tell me about the types of preventive healthcare that you do offer to patients?

P: preventative healthcare that we offer to patients. Umm, everything, low-dose aspirin if that’s been spoken about but for cardio risk obviously, a lot of people are on low-dose aspirin. Do you want to know at a pharmacy level in terms of therapies we initiate there solely and without prescriber’s intervention or just in general what we see?

I: in general

P: in general, so from a prescriber’s end its everything, for diabetics, heart health, obesity, smoking cessation, mental health, we see everything. Give me some specific questions and I can give you specific answers.

I: so things like smoking cessation, asthma prevention

P: yep absolutely yeah.

I: so what are some of the medicinal products you would recommend for disease prevention?

P: yep so if I think about the mapping out of my pharmacy, we’ve got a huge area dedicated to smoking cessation, so for preventing all the risk and medical conditions that come with that, so patches, sprays what have you. And if I go to the other side, I think of gut health, we initiate a lot of people on fibre supplements, for presenting gastro illnesses, psyllium husk. What else have we got… OTC, that’s really all we see. The few main ones.

I: thank you, and you mentioned a few of the types of products, so what are the factors that would influence you to recommend one product over the other.

P: evidence for a start, and then in terms of, in terms of all other things the same, if you’ve got two products with the same active ingredient then it comes down to value and what the patient wants as well. You know, so palatability, compliance, you’re not going to tell them to sprinkle granular psyllium husk on their Weet Bix if they’d much rather have an orange juice drink every day, you’d go the Metamucil. So customer and patient focussed, because what we recommend is one thing but then whether they’ll actually take it and use it and comply, depends on what their preferences are, you tailor it to them using what you know.

I: great, so evidence, then cost and then form?

P: yeah spot on. They’re probably the three, uh well, form is probably more important than cost. Yeah because you’re not going to recommend something that’s a good price point if it’s not the price point they will take. But evidence first and foremost.

I: so this a very broad question again, well get a bit more specific later. So what do you think are pharmacists’ current role in preventive health?

P: pharmacists’ current role in preventive health is definitely, probably more on the compliance end as opposed to initiation if I’m to be honest. Cos a lot of patients come in very well informed these days, they have encyclopedias at their fingertips with up to date information, a lot of the time they’ve already spoken to their doctor or they’ve al ready spoken to someone who they trust. When they come to the pharmacist, what they’re needing at that end is really just to find the physical product or get their hands on the actual product. So our job at that fore front is to first of all validate what they’re saying or disqualify it, if they’ve come in with some ill formed ideas because that happens a bit.

I: could you expand on that?

P: yeah well sometimes you get people coming in and asking for homeopathic products, so sometimes you get people, doesn’t happen often but that’s just one example, there’s homeopathy, there’s naturopathy, there’s herbal products, there’s things they read in a magazine and then there’s things that the doctors recommended and I’m not necessarily saying that what the doctors recommended is automatically right because it’s come from a doctor’s mouth but then there’s that as well. So it’s helping them navigate that landscape of information and you know point them in the right direction, you know they already have the why so why do I need to take… say… a probiotic, you know, so they come in with the idea of I want to take a probiotic because it’s good for my gut or so they think, you know whereas two people who are qualified would probably know better and know that a faecal transplant as a once off would probably do more good for them than a lifetimes worth of taking oral tablets. So its pointing them in the direction of other products that they might not have considered. So be it fibre supplements or whatever.

I: thank you so how do you keep up to date with new drugs or clinical guidelines

P: yeah were very lucky, there’s a whole plethora of information out there. We get something once a month called the AJP journal which keeps us up with the new medicines that are available, we have reps from various companies that come into our stores probably on a weekly basis, not just prescription but front of counter things as well, we’ve got continued education, its actually initiated by our group, by chemist warehouse for the pharmacists, so we got a whole, we’ve got a myriad of things, they’re probably the three main ones. yep

I: so you mentioned continued education, do you have a preferred method of getting those CPD points.

P: yeah my preferred is online questionnaires because you can do them in your own time, it’s very hard to go to seminars and so forth because of pressures of business and everything else that’s, it’s hard to find the time sometimes, having a family, having kids, but an online questionnaire you can do at 10:30 when everyone’s asleep, take your time reading it and actually digest the material properly. Yep, that’s probably my preferred.

I: great thank you, so just a bit more depth into that, so when there is a change in guidelines how do you find out about them?

P: usually from one of my interns! Yeah because they’re, you know, they’re studying intently and they’re usually the ones to raise it. So usually one of my intern pharmacists or a freshly registered pharmacist, because they’re still touching it they’re still informed their email is still up to date, they’re still getting the information, just being blatantly honest, that’s usually how yeah.

I: no no, that’s great, thank you. So do you think you have any challenges with keeping up to date? And implementing new guidelines?

P: so keeping up to date. Isn’t so hard. New guidelines, yeah I don’t think, I don’t think were even informed all that adequately when new guidelines are brought out, this is the first I’ve heard about this [CCA guidelines].

I: so what are the specific challenges, specific things stopping that?

P: I don’t know, who’s responsible? Who’s responsible? Even if you’ve got a pharmacist or a doctor who’s saying “I want to know, I want to know” you know, when key changes like this occur in the guidelines especially cost benefit wise, you’re telling me a $1 packet of aspirin could potentially save someone’s life from colorectal cancer? So, there’s a whole plethora of things that are probably changing in the guidelines, but I don’t think there’s any prioritisation that’s happening at the moment in terms of what the key messages are. So maybe whoever the decision makers are, need to advertise the best 3 changes, or something, I don’t know. But I think an amendment comes out, and unless you happen to open that page and go to find it, how are you to know. Or unless a representative from the company tells you, how are you meant to know?

I: yeah I like I was saying earlier, they guidelines aren’t reflected in eMIMS or any of the pharmacy guidelines…

P: yeah so even if you were looking for it, you wouldn’t know. That’s a travesty really. It’s not to say that most people aren’t on aspirin anyway, is this low-dose aspirin that were talking, 100mg a day? Well I don’t what the stats are but the majority of the population over the age of 45 are probably on that anyway. So yeah.

I: great, so have you come across the guidelines before?

P: no

I: so I’ve got a quick summary sheet, since were recording, it would be great if you could kind of think out loud, if anything comes to mind while you are reading it, let me know.

P: you should probably change CRC at the top, I know what it is but you and I are talking about it. I know it says it’s there but this is bigger.

I: make it clearer?

P: make it clearer. That’s a bit confusing, 600mg per day has been shown to be effective, but a lower dose may be as effective. Maybe? Or is?

I: this is verbatim from the guidelines.

P: that is the most contradictory thing, it doesn’t even make sense to me.

I: so these high risk cases include people who have lynch syndrome, there’s a lot of evidence for high dosages working, but at the same time there are some dose conformity studies that show that 81mg is usually as effective.

P: yeh that makes sense to me, and this is the groups that should avoid it. Looks good.

I: any comments?

P: no, just a bolder heading.

I: yep, great so this is moreover to give to clinicians themselves, have you come across any evidence for aspirin for colorectal cancer?

P: no

I: great, and do you have any opinions about the potential benefits and harms?

P: benefits, there’s too many to mention, harms, just the ones that we know about you know. So first and foremost if they’re allergic salicylates or anything like that, because it is readily available on the shelf without a script so, a very small risk there, it’s not a very large percentage of the population, but the other ones just gastro, you know peptic ulcers and things like that, other than that, no issues, low-dose? Go for your life. Yeah.

I: so how receptive do you think patients would feel about using aspirin to reduce their risk of bowel cancer?

P: it’s been around for a very long time, it’s not a new drug, I don’t think they would have any issues, just like with blood pressure tablets, they don’t have any issues. You know in the news, aspirin is featuring more and more in the news, as being a preventative for cancers, not just colorectal cancer. Yeah I can’t think of any time a patient has come in and said, “no I don’t want to take aspirin because of this” I can’t think of any negative news story. Yeah. I can’t see any issues, and I can’t see any of my patients having any issues.

I: have patients ever come to you with feedback about their aspirin use?

P: no, nope, there’s only ever two things that ever come out with low-dose aspirin, occasionally it’s this, its “I don’t want to take this one, I want to take the coated one the Cartia because its enteric coated and the doctor said its better for my gut. That’s about as much negativity I hear about aspirin, and in all of 15 years of practicing, I’ve never once heard a customer say “I don’t want to take aspirin because it’s bad for me or because of this” I’ve never had any resistance, I’ve never even heard of anyone not wanting to take it. Whereas with other things, you do hear about it. You can hear about it high-dose anti-inflammatories or Voltaren, Nurofen, not with aspirin. So I think its resoundingly a positive audience. Or a receptive audience.

I: so what do you think are the barriers to pharmacists counselling patients aged 50-70 about using aspirin to prevent bowel cancer, so just as a scenario, someone walks into the pharmacy, what barriers are there.

P: as in if someone were to walk in right now into a pharmacy today?

I: sure, as a scenario.

P: I think the first point, does the pharmacist even know? I mean I didn’t know about this. If someone came to me 4 weeks ago and said I want to take low-dose aspirin because it’s going to prevent colorectal cancer, I’d say where did you hear about it and what’s the evidence, I haven’t heard about this. I’m not saying that there’d immediately be scepticism, what I am saying is just like in the first instance I was talking about patients coming in with ill-formed ideas, you just want to make sure this isn’t one of them, because it’s very rare that the patient is the one educating you. Usually it’s the other way around. So that’s the first thing. I think that’s going to be the first resistance point is they’re going to come into a pharmacy and if they’re asking the pharmacist with aspirin should I take, is it the 100, the 300 or 600, the first thing the pharmacist is going to say is “no you mean heart health” because we take low-dose to thin the blood, it’s got nothing to do with the gut. So I think that’s the first thing that’s going to happen. I don’t see any other barriers, its literally going to be education of the pharmacists or the doctors or the whoever.

I: so if they did know?

P: if they did know, you’re not going to have any issues, it’s not scheduled to be stored behind the counter, its readily available on the shelf, for the most part they probably won’t even ask the pharmacist or the pharmacy assistant, they’re just going to grab it and go. And if they don’t, then they might ask the pharmacist, the pharmacist isn’t going to have any issues, they’ll just make sure it’s appropriate, they’ll make sure they don’t have stomach ulcers, gastric issues or allergies. And they’ll obviously just confirm that they’re not on any other medication that might interfere or interact, you know warfarin or anything else.

I: and what about initiating the conversation?

P: initiating the conversation form the patient end?

I: from the pharmacist to the patient.

P: umm, I don’t see the pharmacist initiating that conversation, because there are so many people picking up a packet of aspirin right now. Uhh so I don’t think there’s going to be any issues from the pharmacist, in fact the conversation won’t even be initiated, it might be something along the lines of you know, “what are you doing here and is there something I can help you with. What are you looking for?”. So this isn’t a conversation that’s going to be initiated from the pharmacist end. Even, yeah, coming in fresh, I don’t see that happening. You know most pharmacies… I’m just trying to imagine this happening, and what scenario, I can’t imagine it.

I: so imagine a 50-70 year old walks into the pharmacy looking for something, and you might think it’s reasonable to bring it up, would you have any issues initiating it at all?

P: yeah I would now because I know about it, yeah so I’m trying to imagine two things, I’m trying to imagine a pharmacist, and I’m trying to imagine me. I think there’s always going to be a stigma associated with starting something new. You don’t really want to be the one starting something unless its commonplace or common practice. This isn’t something we’ve been told to do en masse. So unless it’s a concern that was brought up or initiated by the patient, I don’t think it’s something that pharmacists are going to do openly and willingly because there’s risk that comes with doing something that’s not commonplace. You end up being a pioneer, you end up being the lonely goat at the front of the pack. So would I be happy to have that conversation, yeahhh, would most pharmacists? Probably not,

I: why do you think that is, and do you think it’s reasonable to initiate the conversation.

P: I do think it’s reasonable to initiate the conversation because you talking about the potential of saving someone’s life and doing good. I just think, that something so big and heavy and that is chronic management is a conversation that usually happens at the doctor’s clinic. Pharmacists aren’t there to initiate treatments for chronic conditions or chronic preventions. Pharmacists are there very much as an acute setting, it’s the way it’s always been. You come in for a Ventolin but if you want the preventer and you want an asthma plan then you got to go to the doctor. You come in for Ural but if you’re getting recurrent UTIs you have to go for antibiotics, you have to go the doctor, you have to get a blood test, find out why that’s the case. Arthritis? No worries, if you want some Voltaren so you can play golf today here it is, if you want more you have to go to the doctor, have the tests, have the scans. So it’s because colorectal cancer isn’t something that’s an acutely managed thing, it’s something that’s ongoing, and the other thing is the doctor needs to be fully aware of everything that their patients are taking, especially aspirin, because it interferes with medications and has implications for gut health in terms of upper gut, you know, if the doctor finds some ulcers down the track, the patient might not even be aware but the doctor had they have known they were on aspirin… there’s a whole heap of things that come into it, the doctor needs to be made aware. And if the pharmacist initiates that, are we just trusting that the patient will also let their doctor know that they’ve started on the aspirin. So there’s a whole number of things to think about, but fundamentally, pharmacists aren’t there to prescribe for chronic conditions, they are there to manage chronic conditions, they are there to manage chronic conditions. the prescribing, the initiating is fundamentally done by the prescribers’ end.

I: do you think there’s a role that pharmacists could play then?

P: absolutely, the role is to, help with compliance, show them the best form, you know, a packet of aspirin can cost anywhere between $3 and $18 depending on which one. It’s to ensure they do take it, they do follow through. Helping them with that, helping them on how to take it, you know minimise the risk, of peptic ulcers and everything else that might occur and that’s by having it with something to eat in the morning, encouraging them to have the conversation and also just reinforcement because even if the doctor says, a lot of the time the patients can come in sceptical, and the hierarchy of trustworthiness it changes year to year, but sometimes its doctors first, pharmacists second, sometimes its pharmacists first and doctors second. So having that second health professional say “nope, that’s right, that’s true, and this is accurate”, is positive. yeah

I: great, thank you. So we’ve got a little infographic, to communicate the risks and harms both for patients and clinicians, same activity as before, if you could think out loud as you read through it, that would be great.

P: what am I looking at, what does this mean? No aspirin, aspirin, difference, are these the cases of bowel cancer?

I: yep, so in 10,000 people, those are the cases for no aspirin, aspirin…

P: oh ok, so 131 had bowel cancer, with aspirin 99. There was hardly any difference in the number of people having strokes?? Wow… and more people had bleeding from the stomach and gut, well that’s not surprising, but… pretty decent, 30% drop in those two things. Cool.

I: any comments at all?

P: did you say this was for patients as well, so where would they find this or first see this?

I: so do you think this would help pharmacists have the conversation? Maybe in the form of a poster? Its more as a communication tool at the moment.

P: I think if you had to use a graphic, yes. But I, personally don’t think there’s a need, because we’re talking about one thing here which is that [CRC] and you’re just telling them that aspirin will reduce the incidence. I think this would just complicate things. And again, just being frank and honest, because we are talking about one thing and it’s not even explaining how it works. You know if anything people would want to understand why, why it does that? Why is it that low-dose aspirin does that? If anything, that’s going to be the question or the sticking point from the patient end. And uhh what are the risks, is there any problem, no, but it’s all good, great. So if anything, it’s probably going to scare them once you get to this bit [bleeding from stomach and gut risk], so its saying that it’s not for no risk, there might also be increased risk of bleeding from stomach and gut. But no cancer! Yeah so it’s sort of like better of two evils. But yeah I just don’t think it’s something that will help the cause. Yeah just clutter the message.

I: well thank you, that’s actually the bulk of it, any other comments you’d like to add at all?

P: no, great work, you’re doing a great thing. Even if one life is saved from this it’s all worth it. Any questions… no. I think it’s good.

I: great thank you, I’ll turn these off now.

**Field Notes**