**PH09**

I: so we start off pretty broad, could you please tell me about the types of preventative healthcare that you offer to patients?

P: I think as pharmacists, we don’t tend to generally, I suppose being a pharmacist, it’s more I’m seeing the end results unfortunately, so not preventative heath as such. So I would say minimal because of where we’re situated in the health food chain.

I: so would you say it’s more acute care?

P: yes it is acute slash then going on to pall [palliative] care. That’s clinically correct. Yep.

I: thank you, would there be any sorts of preventive care that you do recommend to patients, maybe smoking cessation, counselling, lifestyle counselling.

P:in cardiac units yes, but it’s not a general program that has been rolled out at the hospital where I’m working at, obviously I am aware that it is available at other hospitals, but it’s not something that is rolled out in a formal manner.

I: great thank you, so if you could think of any would you have any products that you would recommend for disease prevention to patients? Or is it completely acute care?

P: I would say it’s completely acute care based on where I am working at, because being a hospital pharmacist, we don’t tend to have that aspect of pharmacy, it’s very proscribed and prescribed rather than offering opinions which I suppose would be very different to a community pharmacist who is a primary carer. I suppose being a tertiary carer.

I: so could you please tell me your current role?

P: my current role is actually as a floater pharmacist but its specifically more in the oncology setting, which is in an acute oncology setting in the chemo day unit and also covering the ward where there are the repercussions of chemo treatment. Leading on to palliative care and end of life care. And on the other aspect is general outpatient dispensary pharmacy in the main site.

I: great thank you. So what do you think are pharmacists’ current role in preventive health overall, including hospital pharmacists.

P: the preventative role I would say is just better health education to patients, so what you cited before about smoking cessation which has been shown to be linked to obviously lung cancer essentially diet control is equally important especially in diabetic patients who are non-insulin dependent but essentially… the question was whether there was any other preventative…?

I: it’s what do you think are pharmacists’ current role…

P: it’s still very much just treating the illness, which could then be expanded to more preventative measures but no, I would say that the current role from how I see it is very much putting out fires rather than preventing the fire happening.

I: so whose role do you think preventing those fires is?

P: the primary carer, so once again I suppose, yes pharmacists in conjunction with their primary health carer, their GP, could be offering lifestyle changes and perhaps offering any proven therapy that could perhaps prevent occurrences of long term chronic disease which would be impacting on our health budget.

I: yep, is there a reason you think its “proven”?

P: I suppose it would be based on randomised controlled trials, because having been an oncology pharmacist, and western medicine in particular is very, very evidence based. But having come across a lot of actual patients who then based on being oncology patients they tend to clutch at straws and obviously want to latch on to any therapy but in a way that’s where charlatans come in, because they are preying on people’s desire to live at all costs. And that has been proven even recently by a person in the media who said that by eating certain diets she was able to cure her cancer, and I suppose cancer is one of the, big, scary illnesses in the western world.

I: thank you. So kind of a follow-up to that, what do you think are your views about pharmacists playing a larger role in preventive healthcare?

P: I would definitely support it, as in and, not having been in the undergraduate world I’m not, I suppose I’m uncertain what is being taught in the lecture theatres, but definitely population preventative health would be the way to go. Even though the whole world is generally aging. And inculcating healthy habits, whether it’s exercise, everything in moderation, diet, but unfortunately I suppose what we’re seeing also sort of professional exposure, liabilities for other sorts of cancers like mesothelioma etc.

I: do you think those are issues as well?

P: hopefully that is something I suppose are aware but even now where we’re sitting in Melbourne it’s become sort of construction zone, and nobody really knows what are the effects of certain materials, I mean asbestos was proven so nobody uses it we would hope but there might be new substances, silica etc. fibres, it’s still unknown, and maybe even something as obscure as everybody using the mobile phones, what are the rays doing?

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

P: tends to be more I suppose continued education from the professional journals I subscribe to and being a society of hospital pharmacists’ member as well as the ISOC, which is the international society of oncology practitioners, so we get journals and we get I suppose chat questions that are raised among colleagues and just attending continued education within the hospitals. So being a hospital pharmacist I suppose it’s a skewed picture because we are very spoilt in that, supposedly were at the cutting edge of what research, what research papers come out and therefore that’s how it is.

I: great, that’s why it’s so nice to speak to you! hahaha so you mentioned professional journals, which journals do you commonly use?

P: it would be the journal of oncology pharmacy practice, which belongs to ISOC, and also the SHPA journal, which is just job, that can be read online, and as I said I suppose being in the area that I am in, the other aspects would probably be from the actual drug companies when they are dropping off the latest information about trials.

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

P: it’s usually implemented at the, I think from the unit head and the actual then whether it is actually taken up by the hospital network, after, obviously after they have discussed among their departments yeah.

I: so it kind of filters down to you?

P: correct, and I suppose we’re made aware, we do have I suppose the intranet at our hospital which is called prompt, and they load policies on or procedures and I suppose if its certain guidelines that should be adhered to, that’s how I suppose it’s implemented.

I: thank you, and do you have any challenges you face when with keeping up to date?

P: for sure, I think being a supposedly specialised pharmacist in the area I am, it’s challenging enough. But because as I said I also have a floater role if I do go to another area, there will be lots of drugs that I might not have heard of or interactions so hence we always have to look it up, so that would be a challenge. And I think it’s an ever-expanding challenge as there are sort of a lot more complex drugs coming out and I suppose with also the hopefully, the complexity of the various diseases we are encountering.

I: great, thank you, do you have any ideas how you could overcome these barriers?

P: exchanging ideas with colleagues, I suppose, and talking to colleagues and just I suppose with the, I think that would be the main thing, and I suppose we might get little snippets each week on an email, like a little blog, or a little education blog as to this is, whether it’s condition of the week or drug of the week or this is what we are hoping to roll out.

I: great thank you. Moving on to the guidelines, are you aware of the cancer council guidelines for low-dose aspirin?

P: I wasn’t aware of the guidelines, it was interesting when the actual original papers came out, it was actually over 6 years ago I think, like one of, it was just a general journal club, and one of the pharmacists had actually selected it, obviously it was reported in a reputable journal, and this was like over 6 years ago, I’m sure maybe 7, 8 years ago when it was first reported. And I suppose it’s very catchy in that it’s such a cheap drug and hopefully an easy uptake. But as to the actual guidelines, no, I was not aware there were formal guidelines.

I: so you have come across some of the evidence?

P: I had like heard, as I said, whether it was the first paper, or the inaugural paper, and I just remember it clearly at the journal club, that was discussed at my previous workplace that was over 6 years ago.

I: could you tell me about the journal club?

P: so the journal club essentially, is just, it was held weekly, or every fortnightly, by an, each pharmacist was rostered, and essentially they just selected an article of interest, that they thought could be relevant to clinical practice, and they brought it to the forum, again this was held at lunch time so the actual uptake, it was one our continued educations, and it sort of just stuck in my mind, and where I used to work, colorectal cancer was one of the big solid tumours that we were looking at, that was at WESTERN, so it was very, very big and I suppose it sort of stuck in my mind.

I: thank you, so I have a quick summary sheet, just because we are recording, if you could think out loud as you review that would be great, so if any thoughts come to mind just say them out loud.

P: sure, yes! I suppose there should be actively considered, essentially these are the guidelines but they haven’t actually said which papers or paper they are referring to. For people aged 50-70… I think that’s when the bowel kit comes out as well, at the 50th birthday, so whether this should be I suppose, instilled with the bowel kit for greater uptake, that’s just a possibility. Or placing this particular documentation with the bowel kits that people get as a 50th gift. The 10 years for people essentially is, I’m not sure for the general public what the uptake will be like because 10 years is a long time for them to see the result. I think it’s fairly clear and straightforward, but in terms of, I’m not sure how successful cancer guidelines has been in implementing these guidelines, as I said I wasn’t aware, but you mentioned it has been placed with the primary carers, the general practitioners in the handbook, but the handbook, as I said, I’m not sure how many people actually flip it, to read it. So it’s a fairly, it’s a cheap drug and it’s easy to take, and I think peoples with association with the drug has been more obviously with stroke prevention. So I would assume the general public would be very aware of the drug.

I: so what are your thoughts about the evidence behind them or do you have any concerns about that?

P: I don’t have any concerns, but I’m just wondering like whether there is a referral for like if someone was reading it cold, to say “oh where is it coming from”. Like if it was a lay person, otherwise, no.

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

P: I think the harm obviously is in the aspirin, I mean, there is essentially, which has already been highlighted is that the possible bleeding, and you might have a susceptible patient group who might be a lot more sensitive to it than anticipated. But I can’t remember from the actual trials, what sort of numbers were used for them to actually verify the statement.

I: great, so do you have any views about using low-dose aspirin in general as a preventive medicine? Or experience?

P: no experience, as in personal experience or just...?

I: professional and personal.

P: professionally, I don’t, I haven’t encountered anyone, I suppose, there might have been the odd case of someone bleeding a lot more copiously than anticipated, but once again, whether that’s an anomaly that you can’t actually anticipate uhh which person is going to be particularly sensitive. But I think in terms of compliance, it’s just essentially, people actually taking it regularly and not running out of their meds. For a person that’s normally fit and health, who doesn’t normally take anything, not even vitamins etc., I just, suppose not concerned, but I’m wondering like, what sort of, how long they are going to stick to it because of the so-called 10-year window, there’s no gain to a normal human, that’s the only thing. Cos even when you take a vitamin, I mean especially when they don’t perceive it as an essential, it’s this perception of prevention I think that’s difficult for a person, a patient to get their head around. But obviously people who have been exposed to friends or relatives who have had colorectal cancer, I think would be a lot more… willing, to take it after they have seen the repercussions of what colorectal cancer can do. It’s not glamorous, I suppose, it’s not sexy, so I just worry what sort of uptake. 50 years… yeah 50 is like the new 40! So, essentially I think the big sell is like colorectal cancer, which the Australian government has done well with the kit, but I haven’t, like, I don’t think the uptake is that great, whether people are sort of icky about poo, aspirin is something non-invasive like having to take. So if you have people who already take supplemental therapy, then it’s not an issue. You just get another box of your low-dose aspirin. But for someone who never took anything, who they are the odd patients, who up to 80 have never taken anything, might be a bit difficult.

I: thank you, so you did kind of touch on it, but how receptive do you think people would be about taking aspirin for colorectal cancer?

P: I think if there’s an education campaign, blitz, to inform the public, the lay people, about the actual incidence of colorectal [cancer], then followed up by the solution, then the actual uptake will improve. But as I said… for the lay person, I think it’s something very abstract, and they are saying, it will never happen to me, why should I put myself out to take this extra tablet, albeit it’s a benign, I think the public perception will be that it’s benign [aspirin] but it’s that can they be bother to actually take it. That would be more so, my, that’s my perception of it.

I: I guess because the ideal outcome is nothing happening.

P: correct! And everybody always thinks they are invincible, it won’t happen to them. so hence what I touched on, that if they have actually seen [CRC], and I think whether just an actual, I suppose a reminder campaign as to how common colorectal cancer is, like what in terms of the cancer diseases. Whereas I think breast cancer, is very sexy and glamorous. So, like it you know it has a lot of public awareness, and generally, possibly I think women are a lot more in tune with their health, whereas if we’re looking at statistics, men generally, it’s an ostrich mentality like “it’s not happening to me”. If and when symptoms are presenting.

I: great thank you, so we’ve made an infographic to communicate the risks and benefits of using aspirin, same task as before if you could think out loud that would be great.

P: I suppose looking at this it would make the men wary of taking aspirin because they are looking at difference the bleeding, essentially is, I think that’s what will jump out, at them. obviously the, in the case of cardiac patients, the numbers are significantly large although it’s interesting that whether it’s a campaign from, through the stroke, because the number for stroke is a smaller number than bowel cancer, the 20 vs 32. Which I must say, whether it’s showing my ignorance but I’m quite surprised. Because most people I think equate it more to stroke than to the heart attack. But I suppose for the bleeding, whether that might worry a person looking at this particular graph

I: great, thank you, are there any comments you have about the design, is it easy to understand as well?

P: the actual picture? I presume, is this a graph that would then be rolled out with the guidelines to help people understand pictorially what we’re trying to get at.

I: yeah both for clinicians and patients to help them understand.

P: yes, I think the picture is quite clear as to how many, the incidence. Because this are only the actual events.

I: great thank you, so I have a hypothetical, so what are the barriers to you counselling patients aged 50-70 counselling patients aged 50-70 about using aspirin to prevent bowel cancer?

P: oh, no barriers, I think essentially if you rolled it out to all pharmacists who were exposed to cancer and specifically it was just linked to bowel cancer that as an adjunct that you would offer aspirin as a preventative. So in the first line pharmacists, I think, yeah, if the science is there it would be, I suppose as common as like not over-indulging I suppose in fatty food linked to cholesterol, but I suppose, its essentially to get this guideline out there.

I: yep, so you mentioned before that you’re almost entirely focussed on acute care, so what is stopping you and or hospital pharmacy in recommending things for preventive care?

P: I have a feeling that it’s the actual education, like the emphasis hasn’t been on preventative care, as I said, which is unfortunate whether that was how we were taught pharmacy, but as I said, hopefully that emphasis is changing, but the culture is not there, it’s more the professional culture. I think we are aware of it as we read population health etc., but the actually day-to-day, it doesn’t seem to, I haven’t seen it translated to day-to-day where when pharmacists are counselling for the discharge, generally we discharge medications so in the outpatient setting, I suppose in the outpatient setting there might be time constraints also, because of the nature of public hospital pharmacy departments. But definitely I think it, for me anyway, it’s not in the psyche of the pharmacists, because we are always the end line, its essentially the doctors script, we are just there to produce the medication that is supposed to treat the illness. It’s the mindset!

I: well that’s actually the bulk of the questions, I hope that wasn’t too difficult haha, any other comments you would like to add?

P: no, I think, it’s obviously a good study, I mean there’s evidence with guidelines, but it’s just essentially, it seems to have been lost, like because I’m working in the field and I was wondering what has happened to it, I don’t see people… so whether primary carers, referrers etc. are like, the uptake isn’t there? They’re not convinced? Whether you need another blitz? I’m not sure. This is my… because I’m probably a skewed picture like if you got another person, but I’m just, as I said it was 6, 7 years ago the seminal paper, I think it was, it could have been lancet! something like the lancet…

I: great, do you think any question should added to this interview?

P: no I think you covered all the bases!

**Field Notes**

**OTHER NOTES, JUST TYPING THEM HERE, TALK ABOUT HOW THE EFT WAS CHANGED MID WAY AND ALL THE CRITICISMS FOR BLEEDING JUMPING OUT WERE MINIMISED AFTER WE CHANGED THE COLOUR TO ORANGE INSTEAD OF RED**