

\*SURGICAL MANAGEMENT PREFERENCES STUDY: Interview (Doctor)

\*VENUE: Low MR unit

\*DATE:

\*ID: BSO28

\*INTERVIEWER: DJW

INT: FIRST OF ALL THANK YOU FOR AGREEING TO BE INTERVIEWED, I KNOW YOU'RE BUSY. I'D LIKE TO START WITH QUESTION ONE, WHICH IS ...

\*Q1. HOW LONG HAVE YOU ACTUALLY WORKED IN THIS BREAST UNIT?

Doctor: Right, I've been here as association specialist for two years but I was here as a registrar on the rotation end of it before as well, so a little while.

INT: OK, RIGHT. AND JUST THINKING ABOUT THE SORT OF THE DAY TO DAY RUNNING OF THE SERVICE, THE PHILOSOPHY OF THE UNIT HERE, THE LIKES AND DISLIKES ETC ...

\*Q2. WHAT'S IT LIKE TO WORK AS A SPECIALIST IN THIS BREAST SERVICE?

Doctor: It's a busy unit, lot of patients etc, so it can be quite stressful, but I think, you know, within the unit's quite a, I think it's a good unit and we do all tend to work well together. There's always one or two hiccups [??] but I think overall it's a good place to work, and I certainly enjoy working here.

INT: HOW DOES IT COMPARE TO ANY OTHER PLACE YOU'VE WORKED IN?

Doctor: Well I've worked at Nottingham as well, so, as a research fellow so ...

INT: OH RIGHT, BECAUSE THEY'VE GOT A BIT RESEARCH REPUTATION, I MEAN, YEAH, YEAH.

Doctor: Yeah, that's right, I did my MD thesis there so, erm, you know it's a bit different to Nottingham so it's kind of slightly different protocols and the way we treat things, the way the clinics are run and so on. So, erm, it's just getting used to doing things in different ways really.

INT: IS THERE ANYTHING HERE THAT YOU THINK PARTICULARLY MAKES YOUR JOB EASY TO DO AS A CONSULTANT?

Doctor: Erm [chuckles] easy ...

INT: IT'S NEVER ALWAYS EASY TO THINK ABOUT THE EASY THINGS, BUT WHAT MAKES YOUR JOB EASIER ...

Doctor: I'm trying to think of something to say ... erm, well I think in general that, you know, everyone does try and work together as team. I think the clinic nurses, the breast care nurses are very good here, totally supportive, and so I always try and work with everybody together and that usually works quite well. And if there is a problem we can normally manage to find a solution to it one way or the other.

INT: AND THE CONVERSE SIDE OF IT, IS THERE ANYTHING HERE THAT YOU THINK CONSTRAINS OR DOESN'T MAKE YOUR JOB SO EASY?

Doctor: Erm, I think the main problem is too many patients, not enough surgeons at the moment, stress of work, well, there's not enough radiologists, pathologists, all the, you know, whole team [??] and it's, I think that's the main thing really, and clinics always run over because there are too many patients etc. You know sometimes you're having to rush a little bit more than you'd like because, you know, you've got more patients to get through as well.

INT: YOU'VE GOT A WIDE CATCHMENT AREA, HAVEN'T YOU?

Doctor: Mm, 600 cancers a year here, so, it's about the same as Nottingham, patients, it's one of the largest centres in the country actually.

INT: YEAH, EXACTLY.

Doctor: You know, we, people don't realise that Leicester is so busy, I think, [???

INT: I MEAN I DIDN'T EVEN REALISE, I MEAN, WHEN I CAME HERE TO DO, I WAS DOING PATIENT INTERVIEWS AROUND LEICESTER AND I WENT TO A GARAGE TO GET A MAP OF LEICESTESHIRE AND SOME COMPANIES DON'T DO A MAP OF LECIESTERSHIRE, THEY DO LEICESTER CITY AND MARKET HARBROUGH ...

Doctor: Yeah, and then all the [???] as well ...

INT: YEAH, THERE'S A NEW ONE JUST COME OUT OF LECIESTERSHIRE AND IT'S A MASSIVE AREA, IT'S A HUGE PLACE.

Doctor: It is, it's a huge area.

INT: SO, LET ME SEE, WHERE ARE WE?

\*Q3. DO YOU FEEL THAT PROFESSIONALS HAVE DIFFERENT WAYS OF WORKING AND WHICH, AND STYLES OF WORKING, AND WHICH SORT OF STYLES HAVE YOU OBSERVED, WHICH WAYS OF WORKING HAVE YOU OBSERVED SINCE YOU'VE BEEN HERE?

Doctor: Well I suppose I'm in a unique position because I work with everybody and I was here as a registrar as well so I'm used to the different styles, of course every consultant has a different too. Erm, I mean there are different characters here within the consultants on the breast unit who do have sort of different ways and sort of different manners with patients and so on. You know, one of the surgeons is really quite forceful and another one is really quite sort of meek and mild and sort of almost too gentle really for being a surgeon. So, you know, there's all the different styles within the unit and people do things in slightly different ways, so I'm just used to fitting in with all those styles really.

INT: YEAH, AND AMONG THE BREAST CARE NURSES, HAVE YOU OBSERVED DIFFERENT STYLES OF WORKING THERE OR ...?

Doctor: Erm, no, I suppose that they tend to be more unified really, although again you've got the different personalities of the nurses ...

INT: OF COURSE, YEAH.

Doctor: ... overall I think they do try and work to the, sort of the same sort of standards and the advice they give is, you know, pretty standardised really, and try and sort of work along the same lines so it's consistent.

INT: I'D LIKE TO MOVE ON A LITTLE BIT TO BEFORE A CONSULTATION WHERE A DIAGNOSIS IS TO BE GIVEN AND FROM NOW ON I'D LIKE US TO FOCUS JUST ON NEWLY DIAGNOSED BREAST CANCER PATIENTS ...

\*Q4. WHEN IS YOUR REGULAR BREAST MDT MEETING HELD IN RELATION TO THE CLINIC WHERE PATIENTS ARE USUALLY GIVEN THEIR DIAGNOSIS OF BREAST CANCER?

Doctor: Right, well, because we've got the one-stop clinics, so patients will come up and they often have the results of cytology on the same day, they may get the initial, or provisional diagnosis of cancer before we have the MDT to discuss them, but we normally see them back the next week because they have staging investigations and so on, so between them being seen the first time and given that initial diagnosis, they would be discussed at the MDT and then when they come back the next clinic they would have been discussed.

INT: YEAH, THE MDT'S WHEN, IS IT, MONDAY, YEAH?

Doctor: Monday, yeah.

INT: AND DO YOU ATTEND THE MDT?

Doctor: I do, I actually, erm, I co-chair the MDT with [??] ...

INT: OH RIGHT.

Doctor: So we sort of try and share it between us so, depending on who's away and who's not. So I do go through some of the notes, pre-op core biopsies and so on, myself and Liz'll go through the symptomatic cases.

INT: THAT'S A BIT OF A JOB, YOU SEE ABOUT 50 A WEEK OR SOMETHING, DON'T YOU?

Doctor: Particularly when you've had a bank holiday on the Monday, like this coming week's gonna be a right nightmare.

INT: OH, YEAH, I CAN IMAGINE. SO THE NEXT QUESTION IS ...

\*Q5. HOW DO YOU USUALLY FEEL AFTER AN MDT MEETING?

Doctor: There's a stress. I, often I have to leave early because I have a theatre list at 1.30 and it finishes at 2.00 so in a way I miss some of it, which is a shame, but I usually miss the, some of the post-op results when they're talking about the surgical results and then the adjuvant treatment so, whilst I do miss some of the pre-op going through, the patients as well sometimes depending on when I have to leave, so it's not ideal, erm, but at least I feel like I've gone through a lot of the notes, and I know what's happening with the patients even though I've not been there for the final discussion. But again sometimes some of the patients I've operated on and I don't, I'm not actually there when the surgical results are discussed: that's a shame really because I often miss knowing the full details, and then I don't always see them back in clinic because they belong to the consultant. So, you know, from continuity of care it isn't always brilliant. Just from my, you know, not for the patient, but from me to know what's happened to that patient I operated on. And it's normally so busy it's difficult to chase up every patient through all the different clinics to find out.

INT: SO WHEN DO YOU, WHEN IS YOUR CLINICS NORMALLY RUN?

Doctor: Well I operate Monday afternoon; I join Mr Everson Tuesday morning in theatre or Miss [??], I do a clinic with Mr Everson Tuesday afternoon, his patients; I often cover for Miss [??] on her Wednesday clinic if she's away; I do my own general surgery clinic Wednesday afternoon; Thursday afternoon I do Anne Stotter's clinic with her - so, you know, I'm working with all the different consultants really, so I see patients, like, for everyone really and all different diagnoses. It's trying to keep track of everybody. And then I operate for Miss Stotter, I operate for Mr Windle; I operate for Mr Everson[?] as well, so I'm you know, operating on their patients too.

INT: RIGHT, OK. YOU'RE A BUSY PERSON [CHUCKLES]

Doctor: Yes.

\*Q6. IF, AT A PRIOR CONSULTATION, IT WAS SUSPECTED THAT A PATIENT HAD A BREAST CANCER, IS THERE ANYTHING YOU, OR ANYONE ELSE IN THE TEAM WOULD SAY TO THEM AT THAT STAGE?

Doctor: Sorry, can you just repeat the ... that question again, the beginning ...

INT: YEAH, IF AT A PRIOR CONSULTATION, FROM WHEN THEY ACTUALLY RECEIVE THEIR DIAGNOSIS, IT WAS SUSPECTED THAT A PATIENT HAD A BREAST CANCER, IS THERE ANYTHING YOU OR ANYONE ELSE IN THE TEAM WOULD SAY AT THAT STAGE TO THEM?

Doctor: Before we had the definite diagnosis?

INT: MM.

Doctor: Erm, I think I personally judge sort of what the situation is, what that patient's like, erm, if I think there's a very strong likelihood that this is going to be malignant then I, normally I would say, 'Look, we do think this may well be a cancer, obviously we want to, you know, get the final confirmation ...' but again I would tailor that depending what the patient was like. If the patient was extremely anxious or maybe elderly and not able to cope with that information, I would maybe tell her and say that we do need to do some more tests and we want to get the final result and then we'll see that, but it's an individual thing really with what the patients are like.

\*Q7. AND THINKING ABOUT WHEN PATIENTS ARE RECEIVING THE NEWS THEY HAVE BREAST CANCER ... WHAT WAY DO YOU THINK THE PATIENTS THEMSELVES ARE PREPARED FOR THAT NEWS?

Doctor: Again, everyone's different. I think so me patients come up with a lump and they're, you know, they've got a pretty good idea what it is, and other patients it's a complete surprise. So ...

INT: ESPECIALLY IF THEY'VE COME THROUGH SCREENING.

Doctor: That's right, or if it's a young patient come up and they think they've got a benign lump and it turns out to be otherwise, so again it could be the whole spectrum really of patients and responses that you get, to try and tailor what you say according to what the situation is.

\*Q8. AND PRIOR TO A CONSULTATION WHERE YOU KNOW THAT A PATIENT WILL BE GIVEN A DIAGNOSIS OF BREAST CANCER, DO YOU HAVE EXPECTATIONS ABOUT HOW THAT CONSULTATION GOING TO GO AND, YES, WHAT WOULD THEY BASED ON?

Doctor: They would depend on had I personally seen that patient before, as I say I sometimes do clinics when someone else has seen the patient before, then I'm seeing the patient for the first time and it's their second consultation, so I've got the results to give them but I haven't met that patient yet. Sometimes I've seen the patient before and they've had the initial core biopsy or whatever, they're coming back for the results. So in some ways that's easier because you've met the patient before and you've already hopefully got a bit of a rapport with the patient. So again you have to, I tailor it depending what the situation is. I tend to have my own pattern of what I say to patients when they've got a diagnosis of cancer, which I tend to stick to with variations, again depending on how the patient is reacting really and responding.

\*Q9. AND BEFORE SUCH A CONSULTATION WHERE YOU'RE GOING TO BE GIVING A DAIGNOSIS OF BREAST CANCER, CAN YOU DESCRIBE YOUR FEELINGS BEFORE THAT CONSULTATION?

Doctor: Again, variable depending on the situation of the patient, whether they're young; whether they're older; whether it's something that the patient's likely to be expecting or whether it is going to be a complete surprise; sometimes we know there's been a very anxious patient and we know the diagnosis is cancer and sort of sitting with the breast care nurses before we go in, saying, 'Oh, OK, you know, this might be difficult,' so again you just, it's individual patient really.

INT: YEAH. AND NOW MOVING TO THE ACTUAL CONSULTATION WITH THE NEWLY-DIAGNOSED PATIENT ...

\*Q10. CAN YOU PLEASE TALK ME THROUGH WHAT HAPPENS IN A CONSULTATION, JUST GENERALLY, WHERE DIAGNOSIS AND TREATMENT OPTIONS ARE BEING DISCUSSED?

Doctor: In general, me personally?

INT: JUST WITH YOU, YEAH.

Doctor: Normally I would, erm, start with saying, 'Well I'm afraid the tests have confirmed it is a cancer,' or the biopsy or whatever, and then try and just give them a bit of time, you know, to react to that, or respond to that. And then when I think the patient is ready I'll go on to start talking about what the treatment is likely to involve, and then normally I say something like, 'Well the initial treatment is surgery,' and then I will talk about mastectomy or wide local, depending on what was appropriate, erm, with the patient. And then I'd say, erm, 'Additional to that it may be that you need some additional back-up treatment such as chemotherapy and radiotherapy and that will depend on the results of the surgery and what it looks like down the microscope, etc, and whether there was any nodes involved, etc, so that's sort of the standard sort of way I work in the consultation.

INT: OK. AND WHEN YOU'RE SORT OF CONSULTING WITH PATIENTS, WHO ELSE TENDS TO BE IN THE ROOM A THE SAME TIME?

Doctor: We always try and have a breast care nurse when it's a cancer diagnosis patient and we're talking about diagnosis and treatment, I think almost universally we do have a breast care nurse present.

INT: MM, IS THERE ANYBOYD ELSE IN THE ROOM AT THE TIME?

Doctor: There may be a clinic nurse and very occasionally we might have a junior or a medical student, a registrar or someone extra, but most times we don't, it's just the breast care nurse and/or the clinic nurse.

INT: AND DOES A PATIENT TYPICALLY BRING ANYBODY WITH THEM?

Doctor: Yeah, erm, usually they have, well quite often then have a relative and some patients are by themselves, a lot do have someone else with them.

INT: RIGHT, OK. AND WHEN YOU'RE SORT OF DISCUSSING THINGS LIKE TREATMENT OPTIONS AND DIAGNOSIS, DO YOU USE ANY SORT OF VISUAL AIDS OR TOOLS, X-RAYS, MAMMOGRAMS, DIAGRAMS, ANY DRAWING DIAGRAMS, PHOTOGRAPHS, ANYTHING LIKE THAT?

Doctor: I don't use any formal visual aids. I, sometimes when I'm talking about wide local excision, when I'm talking about the margins I'll sort of just draw like that, and then I try to explain if it's too close to one margin, so I say we try and sort of get it in the middle but then if it's too close to that one

sides and, you know, we might need to take an extra bit there. If they want to see the mammograms then we would show them but most patients don't ask to see, occasionally a patient will do and if they do then we bring them through to the x-ray box and will show them this is where the tumour is and so on.

INT: OK. AND DO YOU SPEND ANY ADDIKTIONAL TIME WITH A PATIENT AFTER THE CONSULTATION?

Doctor: What we tend to do is we do the initial consultation with the doctor, they're going through the diagnosis and the treatment, and then we leave the patient with the breast care nurse, they often take them into the, what's it called, the, erm, informal room, counselling room ...

INT: COUNSELLING ROOM, YEAH.

Doctor: ... yeah, and will go through things again and any extra questions. We just don't have the time to spend ages with these patients unfortunately, so the breast care nurses [???] you know, usually back us up, what we have said and then if a patient is worried and not quite understood or anything, then the breast care nurse would go through it again. But I hope that normally they do understand [chuckles] what I've said in that sort of situation.

INT: AND DO YOU SEE THE PATIENT AT ANY OTHER TIME BEFORE, IN BETWEEN THAT CONSULTATION AND THE ACTUAL SURGERY?

Doctor: It depends if they're coming back for staging tests, and normally when we first see them with the initial diagnosis we talk about the diagnosis and then touch on the treatment and, if they were suitable for a wide local or a mastectomy, either, I talk about both, say either is possible and both are just as safe as long as the margins are clear, but you do need to have radiotherapy with a wide local. So I go through all these facts. Erm, sometimes the patients say definitely, 'Yes I want ...' one or the other, but if they're unsure then we give them written information on both operations, then they normally have the staging blood tests and chest x-ray and then they'll come back the following week, so they've had a week to think about things. So then we have another consultation and talk through the options again on their second visit and try and help them come to a definite decision on the surgery that they'd like. So normally we see them like the twice and then they'll be given a date for their surgery on the second visit when they're going to come in for surgery.

INT: I'D LIKE TO MOVE ON TO ABOUT PATIENTS' INFORMATION NEEDS NOW ...

\*Q11. IN YOUR EXPERIENCE, WHAT DO PATIENTS TEND TO KNOW ABOUT BREAST CANCER AND ITS TREATMENT OPTIONS BEFORE THEY COME TO SEE YOU?

Doctor: Wide variation again. You have, you know, quite well-informed; well-educated patient who's been on the internet and read it all up and knows quite a bit before they come to clinic; erm, ask a lot of sensible questions ... then you go right to the other end the, you know, sort of patients just don't have a clue and, erm, 'Whatever you say, Doctor,' sort of thing. So again you have a huge variation really

INT: DO YOU THINK IT MAKES FOR AN EASIER OR HARDER CONSULTATION PROCESS WITH SOMEONE WHO KNOWS A LOT OR VERY LITTLE, WHAT DO YOU THINK?

Doctor: Erm, I think it's easiest if patients don't know anything. If patients have been reading up a lot or looking up on the internet they can sometimes get incorrect information or information that doesn't quite apply to their situation and that can be ...

INT: ESPECIALLY ON AMERICAN WEBSITES AND THAT, YEAH.

Doctor: Exactly. Erm, and that can make matters more complicated. And the other thing is all the, you know, new cancer drugs and so on that come out on the news but they're not readily available because they're all research drugs and patients will be asking about that and you have to say, 'Well, we're not actually using that at the moment, it's not in standard practice,' so sometimes that can be more difficult really.

\*Q12. WHAT DO YOU THINK ARE THE MOST IMPORTANT PIECES OF INFORMATION PATIENTS WANT OR NEED TO KNOW ABOUT THEIR DIAGNOSIS FIRST, AND WHEN ARE THEY GENERALLY RAISED?

Doctor: Erm ... I think the main things at the initial, on initial diagnosis is Can it treated? Can it be cured? Am I going to die? That sort of thing I think is foremost in the patient's mind.

INT: AND WHEN YOU'RE DISCUSSING THINGS LIKE DIAGNOSIS, IS THERE ANY INFORMATION PATIENTS PARTICULARLY DON'T UNDERSTAND VERY WELL?

Doctor: Erm ...

INT: JUST GENERALLY.

Doctor: Let me think. I think sometimes if it's DCIS rather than invasive, sometimes that concept is difficult to explain to some patients. Erm, but I mean most patients I think tend to get the general idea, whether they understand the fine details or not, again you sort of tailor how much sort of medical, technical information you give them, depending on what you think the patient's capable to understand and take in. So I mean I personally try and tailor the level of what I say to them as to that individual of the level I think they're going to be able to understand. If that makes sense.

\*Q13. AND WHAT DO YOU THINK ARE THE MOST IMPORTANT PIECES OF INFORMATION PATIENTS NEED OR WANT TO KNOW ABOUT THEIR TREATMENT OPTIONS AND WHEN ARE THEY GENERALLY RAISED?

Doctor: Well they want to know what does treatment involve, and when, certainly surgery, when are they going to have the surgery, that's certainly one of the main things they want to know, 'Well when is my operation going to be?' A lot of patients they just want to have things done as quickly as possible ...

INT: YEAH, ABSOLUTELY.

Doctor: ... and get it over and done with.

INT: AND WHEN YOU'RE TALKING ABOUT TREATMENT OPTIONS, IS THERE ANY INFORMATION WHICH IS UNDERSTOOD PARTICULARLY POORLY OR NOT UNDERSTOOD AT ALL?

Doctor: I think that in general, I think that as surgeons we maybe don't talk about radiotherapy after a wide local in enough detail and what that actually involves, because I mean we often say to patients, 'Oh, you know, well we can just take some of the breast but you will need radiotherapy afterwards.' I always try and say to patients, 'Well it does involve coming up for five weeks every day, you know, treatments once a day for five weeks,' and I think often we tend to pass over on that and don't explain that, you know, in enough detail. I think things like chemotherapy we tend to just give the basics and leave the final detail of that to the oncologist. You know, patients often worry 'Am I going to lose my hair?' 'Is that the treatment you lose your hair?' A lot of

patients think that radiotherapy is the treatment they'd lose their hair so we try and correct that for them and explain the differences between the two. And they may not need the chemotherapy.

INT: I'D LIKE TO MOVE ON NOW TO WHAT A PATIENT IS OFFERED IN TERMS OF TREATMENT.

\*Q14. WITHIN THE CONTEXT OF THE UNIT GUIDELINES AND PUBLISHED RESEARCH, CAN YOU DESCRIBE THE FACTORS THAT WOULD LEAD YOUR TEAM TO OFFER A PATIENT ...

\*a. FIRST OF ALL, ONLY BREAST CONSERVATION SURGERY

Doctor: Only breast conservation ...

INT: YEAH, MM.

Doctor: I, personally, I think that we should talk about mastectomy for any patient really, even if they've got the tiniest small tumour which we know, you know, in the [??] which would be ideal for wide local. I know some surgeons in this unit, you know, don't like offering mastectomy for that sort of situation, but I think that, I always say that there's two options: we can either remove the whole breast or we can just take the breast and small tissue around where the tumour is and, if it is a situation where I think a wide local is by far preferable, I would say, I would say to them, 'Well I think in your case, you know, this is probably the better option and you'd be very suitable to do this and we wouldn't need to take the whole breast.' But I do always try and talk about both options to patients. So I think really the, there's hardly ever any sort of situations where it has to be a wide local and a mastectomy isn't possible. I mean there may be a patient who's ill and you want a very quick operation and that sort of thing, but having, you know, just positional only you still need to talk about both with the patient and 9 times out of 10 they'll go for a wide local, but I think, you know, we're still obliged to talk about either option to that patient. That's my personal view anyway.

\*b. AND WHAT SORT OF FACTORS WOULD LEAD THE TEAM TO OFFER A PATIENT ONLY A MASTECTOMY?

Doctor: Right, well there's size of tumour, erm, here we go up to 4 cms to let the patient have a wide local, but I know at Nottingham they're pretty strict and they try to stick to 3 cms, so I think that's one of the reasons here maybe we've got a higher wide local rate because do offer wide local for some larger tumours than other units. I mean that, personally, that's one of my suspicions as to why we do have a higher rate here, but I'm sure it's not the only reason. Erm, so size, multi-focality obviously, inflammatory locally advanced tumours of course we wouldn't offer wide local. Sometimes after a large tumour's had neo-adjuvant chemo we do offer wide local in that situation, but again I think we're a bit, erm, unsure really as to the safety of that and I think a lot of us do feel happier if that patient has a mastectomy, even if they've got a good tumour response. So I mean that's an area which is, you know, it's not black and white at the moment. I think I've gone through the main ... other reasons are sort of central location in the breast. We do discuss doing a wide local for central lesions although we'd say, 'Look, you need to lose the nipple area,' and we do do that sometimes if the patient wants to do that. So we discuss the options there. And again if the patient has a, is, sort of central tumour in a small breast particularly we would maybe push towards doing a mastectomy there.

\*c. A CHOICE BETWEEN MASTECTOMY & BREAST CONSERVATION SURGERY [Not asked]  
Here

\*d. AND WHAT FACTORS WOULD LEAD YOUR TEAM TO OFFER A PATIENT ANY OTHER TREATMENT SUCH AS CHEMO OR STUFF LIKE THAT?



Doctor: If it's a locally advanced tumour, inflammatory tumour, and you want to try and downsize it before you would consider surgery. And in the elderly patients we do use primary hormone therapy, depending on what the patient's like, if they're not fit for surgery, and sometimes on patient preference. And again sometimes radiotherapy for locally advanced tumours rather than surgery if the patient's elderly, unfit, etc.

INT: THE LITERATURE SUGGESTS THAT PATIENTS VARY IN THE DEGREE OF INVOLVEMENT THEY WANT WHEN THEY'RE MAKING DECISIONS ABOUT WHAT SURGERY TO HAVE. SOME PATIENTS WANT FULL CONTROL; SOME PREFER TO SHARE THE CONTROL; AND OTHERS PREFER IT WHEN THE PROFESSIONALS TAKE THE CONTROL.

\*Q15. FIRST OF ALL, DO YOU THINK THAT PATIENTS ARE GETTING THE DEGREE OF CHOICE THAT THEY WANT?

Doctor: I, when I see patients I try and give them full choice where choice is an option, obviously the situations where they have to have a mastectomy, well there isn't any choice, and I would often say to those patients, 'Well, you know, we do sometimes do just take the lump and some of the breast, but in your situation it isn't possible because of ...' and then I go through the reasons for that patient, try and clarify that for that patient so they know definitely 'I have to have to a mastectomy for these reasons.' Erm, I think the ones where either option is suitable I try and be as impartial as I can, you know, talk about both option to that patient. [chuckles] Has that answered your question?

INT: I THINK IT WAS, THE QUESTION DO YOU THINK THAT PATIENTS ARE GETTING THE DEGREE OF CHOICE THEY [???

Doctor: Degree of choice ... erm, I think possibly some of the other consultants sometimes, I certainly know one of the consultants does say to patients, 'Oh, we'll be able to treat this, just take the lump away,' and not really talk fully about the either option, and, although, you know, I think they try and remember that they should mention mastectomy sometimes they do just tend to say, 'Oh we can just take this lump away for you,' without really talking fully about the choices. I certainly know one of them does that and I think another one probably does that a little bit too.

INT: ONE QUESTION I MEANT TO ASK YOU ABOUT CHOICE WAS WHEN WE WERE TALKING ABOUT WHAT, DO PATIENTS WHEN THEY'RE ACTUALLY, WHEN THEY'RE GIVEN A CHOICE, DO THEY SEEM SURPRISED AT ALL THAT THEY HAVE A CHOICE OR ... WHAT'S USUALLY THEIR REACTION WHEN YOU SAY THAT THERE'S A CHOICE BETWEEN TWO TREATMENTS?

Doctor: I think some patients do find it difficult to understand that just doing the wide excision is as safe as a full mastectomy, and I always try and emphasise that you do have to have the margins clear and there is a small risk that you would need to come back if the margins weren't clear, and you do need to have the radiotherapy, and as long as that's the case and you have the radiotherapy then the two options are just the same in terms of the cancer coming back. And I think some patients do still find that concept difficult because they think surely taking the breast away is, all of the breast, is going to be safer. And even when you've gone through all that in some detail I've had one or two patients, probably more elderly patients, who still don't, can't really get their heads round that.

\*Q16. THINKING ABOUT YOUR EXPERIENCES WITH THE PATIENTS YOU SEE, AND I WAS GOING TO SHOW YOU A CARD, YOU'VE GOT YOUR CHOICES THERE IN FRONT OF YOU, COULD YOU PLEASE LOOK AT THE RESPONSES ON THE SHEET AND TELL ME, DURING CONSULTATIONS, WHO GENERALLY MAKES THE FINAL DECISION ABOUT WHAT SURGICAL TREATMENT TO HAVE? THERE'S FOUR OR FIVE CHOICES THERE, IF YOU'VE HAD A CHANCE TO READ THEM.

Doctor: Is this the one which, when either option is possible?

INT: YES.

Doctor: Yeah. Erm, I mean I'd like to think it's the middle one, 'The patient and I generally share the responsibility for making a final decision.' I mean sometimes it's more one way and more the other way, if someone's definite they want this, or the patient just can't make their mind up and you have to try and help them out, I try, as I say, try and remain in the middle.

INT: OK. I'D LIKE YOU ON NOW TO THE SECTION WHICH IS CALLED 'COMMUNICATING WITH PATIENTS WHO HAVE BREAST CANCER'. AT THIS POINT I SHOULD LIKE US TO TALK, OR TO FOCUS ON PATIENTS IN WHOM, FOR CLINICAL REASONS, MASTECTOMY IS NOT THE ONLY OPTION. RESEARCH HAS IDENTIFIED THAT PATIENTS WITH BREAST CANCER TEND TO FALL INTO ONE OF THREE DECISION MAKING STYLES, THESE ARE THE ACTIVE, COLLABORATIVE AND PASSIVE DECISION MAKING STYLES. IN THIS FINAL SECTION OF THE INTERVIEW I WOULD LIKE TO ASK YOU A FEW QUESTIONS ABOUT HOW YOU FIND COMMUNICATING WITH EACH OF THESE TYPES OF PATIENT DURING THE CONSULTATION PROCESS THAT LEADS TO A FINAL TREATMENT DECISION. OBVIOUSLY I AM AWARE THAT PROBABLY YOU DON'T OF PATIENTS IN TERMS OF ACTIVE, PASSIVE AND COLLABORATIVE, BUT TRY TO FIT INTO THE DEFINITIONS THAT WE HAVE HERE. AND WE'VE DEFINED ACTIVE DECISION MAKERS HERE AS PATIENTS WHO TEND TO MAKE THEIR OWN FINAL TREATMENT DECISIONS EITHER WITH OR WITHOUT SERIOUSLY CONSIDERING THEIR SPECIALIST'S OPINIONS.

\*Q17. FIRSTLY, I WOULD LIKE YOU TO TRY AND THINK OF A SITUATION YOU HAVE HAD WITH A PATIENT WHO WAS ACTIVE ABOUT MAKING DECISIONS. WITHOUT REVEALING ANY CONFIDENTIAL DETAILS, PLEASE TELL ME ABOUT YOUR EXPERIENCE WITH THEM UP TO THE POINT WHEN A TREATMENT DECISION WAS MADE.

Doctor: Right.

INT: COULD YOU THINK OF ANYBODY YOU THOUGHT WAS PARTICULARLY ACTIVE ABOUT DECISION MAKING?

Doctor: Well there is one patient and I think she may well have been mentioned by other people in your interviews. She is a lady who, she did have, I don't think it was an inflammatory, I think it was just quite a large primary tumour and she did have neo-adjuvant chemotherapy to start with, and she got a really good response and the thing shrunk right down. We were still quite concerned and were, you know, advising her that, you know, we thought a mastectomy would be better or her, but she was adamant that she really did want a wide local excision, very image conscious woman. And she actually saw me in one clinic and the thing had really shrunk down and I said to her, 'OK, you know, wide local would be an option here, although, you know, there is still slightly more concern about margins and so on because the tumour was so large to start with.' She did actually have a second opinion in Nottingham [chuckles] and they said she ought to have a mastectomy. Even so she was sticking to, she wanted a wide locale excision and despite myself and Mr, she was a Mr Ellerson[?] patient and, you know, we talked to her on further occasions and still couldn't sway her, she was going to have a wide local excision, and she has in fact had a wide local excision. And I know she's got a particularly [??] breast so we still don't know, in the long term she's probably increased risk for [??] because of the features of the tumour. But you know she was happy with that decision. Although in actual fact I have to say that I saw her ... oh a couple of months back, and she wasn't entirely satisfied because, even though she's got quite a good result from the wide local excision, there's just a little bit of indentation and so she's not fully happy with that even now and she wanted to go and see the plastic surgeons about that. So I think is a highly image-conscious person, she actually works in the media so, you know, she's very, very image-conscious, and

I think for her that was, you know, just as important as the actual, the cancer to her. So I think that's someone that stick out in my mind, in that situation.

INT: HOW DID YOU GET ON WITH THE PATIENT?

Doctor: I got on with her OK. She was one of these patients, her husband was there writing things down all the while when you're doing the interview, you know, and your heart sinks. Erm, asking a lot of questions. She's obviously, you know, read up and knows all the things to ask and so on. And so she, she could be quite a sort of time-consuming paper, and want to talk about things a lot. But, you know, I didn't have any particular problems with her, she was just, you know, took a bit of time [chuckles] and make, just, when you've got someone writing down everything you're saying you're just a bit on edge aren't you, because just make sure that you're, you know, saying the correct things to her.

INT: YEAH, OF COURSE, MM. AND HOW DID YOU FEEL THINGS WENT IN THE ACTUAL PROCESS OF GETTING THE DECISION MAKING ...?

Doctor: Well, as I say, she'd really made the decision and she, she wouldn't be swayed despite us trying to emphasise the increased risk of local recurrence, you know, even despite us doing that, no, that's what she was going to do. And even when she was bothered about the appearance post-op of the little bit of distortion in the breast, although seeing a lot of wide locals it's really pretty good, but to her it's, it is quite a distortion that she's aware of. And even at that stage I said to her, when I said, 'OK, I'll refer you to one of the plastic surgeons, see what they think,' and I was suggesting, well, one of the best ways to really get the shape back to the breast would be to have a mastectomy and then a reconstruction rather than trying to do anything to the breast as it is now, and again she turned that down, 'No, that's the whole reason I was trying to avoid a mastectomy in the first place, and I certainly wouldn't want to do it now,' you know, having gone through everything and not had it before, so she's still very much down the same lines.

INT: DURING THE CONSULTATION PROCESS, WAS THERE ANY INFLUENCES APPARENT AS TO WHY SHE WAS MAKING THE DECISION? YOU JUST MENTIONED SHE WAS VERY IMAGE-CONSCIOUS, WAS THERE ANYTHING ELSE?

Doctor: She didn't volunteer anything else and I didn't pick anything else up, I mean whether there were other things there, I mean there probably were, but I didn't pick them up myself.

INT: OK, AND THINKING ABOUT HOW THINGS WENT AND HOW IT TURNED OUT, HOW SATISFIED WERE YOU WITH THE EXPERIENCE?

Doctor: Erm, well one always has at the back of one's mind I hope she's not going to have problems in the future and, you know, has she had to have the right treatment after all. From her point of view I'm pleased to see that, you know, she had the operation she wanted and I think overall she is satisfied with that. I think she has been extremely fussy, I mean, you know, she's having cancer and she's had it treated, but then I think that's her personality and the way, her body image and the way she views herself and, you know, I think she wants to be perfect. There's not an awful lot more you can do about that [chuckles] is there?

INT: NO, NOT REALLY. WHEN YOU'RE TALKING TO, THINKING MORE NOW ABOUT SORT OF ACTIVES IN GENERAL, WHEN YOU, AT WHAT POINT WHEN YOU'RE ACTUALLY TALKING TO AN ACTIVE DECISION MAKER DO YOU BECOME AWARE THAT THIS PERSON IS SORT OF ACTIVE IN THIS SORT OF DEFINITION?

Doctor: Often when I do the initial, 'Oh there's two ways to treat this,' and normally I say, 'One is to have the full mastectomy,' - I usually say that first and then I talk about wide local, whereas I think other people maybe talk about wide local first and then try and just throw in mastectomy as an after-thought at the end really. So I try and do mastectomy first and then the other. And so I'll talk about the options and all the, make sure the margins are clear and you do need the radiotherapy and what that entails. And then when I get to the end of that I'll say to the patients, 'Well what do you think about what I've said? Have you any views either way at the moment?' and some patients will come straight out, 'Oh, I want to have the wide excision,' so, I think they've made their minds up that's what they want to do.

INT: AND WHEN YOU BECOME AWARE THAT YOU'RE TALKING AN ACTIVE DECISION MAKER, IF YOU LIKE, DOES THAT TAILOR THE WAY YOU APPROACH SOMEBODY OR ...?

Doctor: Erm, I think if a wide local is suitable and, you know, feasible means of treatment, then, no, that's not a problem, that's great, I mean it's easy, they've made a definite decision and then you work along with that and you talk about that surgery and you give them the relevant information for that surgery. And you can be more sort of direct about, you know, what's gonna happen, exactly what's going to happen, etc, and then they know the plan and that's it really. So in some ways it's helpful to have an active decision maker, I suppose.

INT: I'D LIKE TO MOVE ON NOW TO SITUATIONS WITH COLLABORATIVE DECISION MAKERS AND FOR THIS, PURPOSES OF THE STUDY, WE DEFINE COLLABORATIVE DECISION MAKERS AS PATIENTS WHO TEND TO SHARE FINAL TREATMENT RESPONSIBILITIES WITH THEIR SPECIALISTS.

\*Q18. JUST LIKE WE'VE DONE NOW, I'D LIKE YOU TO TRY AND THINK OF SOMEBODY YOU THOUGHT WAS COLLABORATIVE ABOUT MAKING DECISIONS. AND, WITHOUT REVEALING ANY CONFIDENTIAL DETAILS, IF YOU CAN TELL ME A BIT ABOUT THE EXPERIENCE THAT YOU HAD CONSULTATING WITH THEM UP TO THE POINT WHEN THEY MADE A TREATMENT DECISION.

Doctor: There's one lady I've seen recently who comes to mind, she's quite a young, I think still in her 30s, she had an unusual presentation, sort of just like a sort of excretion[?] of the nipple area, not like a Paget's [ph] that you see in older women, and she'd been living up north somewhere and this hadn't been diagnosed properly and come down to Leicester, came to see us and we did a biopsy of this and in fact there was invasive cancer in this. And trouble is it's right in the middle of the breast, erm, but the remainder of the breast on mammogram and examination and all rest of it was normal, so it didn't look like there was any widespread disease anywhere, it was purely in the centre of the breast and the nipple and areola area. So when I talked to her about surgery, erm, I explained, 'Well, it is difficult because it's quite in the centre of the breast, you do need to lose the nipple area and so on, and we can do a wide excision of this but you are going to, you know, have a defect in that breast because it's a difficult area of the breast. And the other option would be to have the full mastectomy and then to consider reconstruction.' So we talked about all this, I think we went through both options really in quite a bit of detail and she was weighing everything up and she didn't make a decision straight away and I think we had a very sensible discussion about both the options. And I think at one stage she was really, she was undecided about which way to go, and what we agreed on in the end was that she would like to try and keep her breast if she could, and it would certainly be worth to try to do the wide local, and it may be that she got quite a good cosmetic result or it may be that it didn't look so good, but she decided that she wanted to try that first and if the margins were clear then that would mean she wouldn't need to lose her whole breast and she wouldn't need further surgery, etc. So that was her final decision, and I think she came to that decision herself with my help, after having gone through really all the options in quite a bit of detail, I spent

quite a bit of time with her. So I really felt happy that she had, you know, made the final decision and that's what she wanted to do, without me pushing her either way really.

INT: YEAH. SO HOW DID YOU GET ON WITH THE PATIENT?

Doctor: Right, I actually did her surgery and it went very well and she's got a really nice result and it's all clear, so, you know, it's all turned out very well and very satisfactorily ...

INT: AH RIGHT, OK.

Doctor: ... for her so I was really pleased about that.

INT: AND HOW SATISFIED DO YOU THINK SHE IS WITH THE WHOLE EXPERIENCE?

Doctor: I think, well, she's very relieved. I know we gave each other a big hug in clinic. [chuckles] You know, I was just pleased for her that it had worked out OK and I think she was just very relieved and she's avoided having to have a mastectomy, etc, so, although she needs the radiotherapy and I think she needs chemotherapy if I remember. I think, was there a node involved [???] I can't remember full details, but she does need to have chemo. But even so, you know, she's got through the surgery part, and that without having to lose her breast and so on.

INT: AND WERE THERE ANY INFLUENCES APPARENT THAT YOU PICKED UP, YOU KNOW, CONSULTING WITH HER?

Doctor: Erm, I think some of her concerns were that, I mean she's only in her 30s, I think she was single, she had a child but was separated and so on, I think she was, you know, just concerned about all these things as well and how, you know, treatment would affect her life following that and future partners, all this sort of thing I think was there at the back of her mind, although she didn't express it directly. So, you know, I think these things were there and it would be nice to try and preserve the breast if she could and so on.

INT: EXACTLY. AT WHAT POINT DO YOU THINK YOU BECOME AWARE YOU'RE TALKING TO A COLLABORATIVE DECISION MAKER?

Doctor: Erm ... I think if they don't come out with 'Yes I want this,' straight away, obviously. [chuckles] Often they're wanting to talk through the options quite a bit and, erm, sometimes, you know, patients sort of turning to their partner and, you know, trying to get feedback from them, and although that's not the patient themselves making the decision, I don't like it when the partner's making the decision for them because I like the patient to. I think a lot of these patients they just, they just want a little bit of support and to talk about stuff and then they do go away and they can make their decision. And often if they don't seem to be able to decide one way or the other and they go away with the breast care nurse and just talk things through with the breast care nurse, they've often made their decision then, after we've seen them and then they come back and say, 'Yes, I want this.' You know, they might come back the second visit and then, yes, they've made their mind up.

INT: DOES THAT KIND OF AWARENESS CHANGE YOUR APPROACH OR TAILOR YOUR APPROACH IN ANY SORT OF WAY TOWARDS THAT PERSON?

Doctor: Erm, if I think that, erm, you know, they're bothered about the one option for whatever reason, I will try and ask, 'Is there anything in particular is bothering you?' or is, you know, they're going towards a mastectomy when they have really got a tumour which is suitable for a wide local excision, I would

try and find out their reasons sort of why they were bothered about the other operation and try and sort of put the fact straight if they still think, 'Oh, that must be more risky, surely, if you don't remove all the breast,' that sort of thing. So to try and make sure they do have all the facts as clearly as possible to try and help them make their decision.

INT: OK. I'D LIKE TO MOVE ON TO THE FINAL CATEGORY WHEN YOU'RE TREATING A PASSIVE DECISION MAKER AND FOR THIS, FOR THESE PURPOSES WE DEFINE PASSIVES AS PATIENTS WHO TEND TO WANT TO LEAVE FINAL TREATMENT DECISIONS TO THEIR SPECIALISTS, EITHER WITH OR WITHOUT THEIR SPECIALISTS SERIOUSLY CONSIDERING THEIR OPINION.

\*Q19. JUST AS WE'VE DONE WITH THE TWO PREVIOUS CATEGORIES, I'D LIKE YOU TO THINK OF A PATIENT IF YOU CAN WHO YOU THOUGHT WAS PASSIVE ABOUT MAKING DECISIONS. AND, WITHOUT REVEALING ANY CONFIDENTIAL DETAILS, TELL ME A LITTLE BIT THEM FROM ...

Doctor: OK. There's, this is a more elderly patient we had, late 60s, early 70s, I've seen recently. She had about 3 cm tumour in the breast, so it would have been OK for wide local excision. I saw her, talked about the diagnosis and then started talking about treatment options and, again, I went through mastectomy, went through the wide excision with all the details about that, margins etc, radiotherapy. Get to the end of the, my conversation, try to get some feedback [chuckles] of any opinion from her, and she just, she really couldn't give me any idea of what she thought she wanted to have at all. I spent quite a bit of time talking through the options again and the breast care nurse was there, so we spent quite a bit of time on the first consultation and was really not getting any feedback at all that she was going one way or the other. I mean sometimes, certainly one of the breast care nurses I work with, even if I'm not able to pick things up, the breast care nurse is quite good at actually picking up where they're going, but we were just getting nowhere. Anyway we gave her written information about both options, and then she went away. She came back the next week for the staging results and, again, we just [chuckles] just no further at all, 'Oh, you know, you tell me, Doctor, I don't know what to do,' going through the two again, you know, wide local's just as safe as so on. So we just really weren't getting anywhere and then you have to start making decisions for the patient and I think I actually re-examined her in the end and I thought the tumour was getting a bit bigger and it was nearly 4 cm instead of the 3, and because of that reason I pushed her towards the mastectomy because I was just a bit concerned about the tumour at that point. And she has had a mastectomy and she's OK. But it's quite frustrating in that situation because you're not wanting to make the decision for the patient and you're trying to lean over backwards to try and get them to make a decision themselves, but sometimes you just can't do it.

INT: YEAH, MM. AND DID YOU GET ON ALL RIGHT WITH HER?

Doctor: Mm, yeah. Yeah, lovely lady but just, you know, just didn't know what to do really.

INT: WAS THERE ANY INFLUENCES APPARENT WHEN YOU WERE TALKING TO HER?

Doctor: Erm ... I don't think so really. I'm, you know, I spent a lot of time talking to her and I'm not really sure how much she actually comprehended fully about what I was trying to say and explain about the difference between the two. I think she was one of these patients still coming back to, well, even though I'd spent ages talking about the wide excision and it was just as safe, she still was coming back to her, you know, 'wouldn't a mastectomy be better to take all the breast tissue away?' business when she, despite spending a, I don't know, I must have spent about an hour in total in the two visits with her, she

still wasn't able to take that in. So just to try and get the patient to understand sometimes is just impossible, whatever you say.

INT: I WAS GOING TO SAY, I MEAN, LOOKING BACK HOW SATISFIED WERE YOU WITH THE EXPERIENCE OF CONSULTING WITH THIS PATIENT?

Doctor: Erm, a bit frustrating but I think in the end I felt, erm, better with the decision that I made for her really because I thought this tumour's getting a bit big really and so I just got that feeling that we ought to be going for a mastectomy really. I mean sometimes you do, you just, you get the feeling one way or the other that that's really what we should be doing and if you've got, erm, if you've got niggling feeling at the back of the your mind then usually it's the best thing to go with that, because that's normally what's the right thing, for whatever reason.

INT: YEAH.

Doctor: I think she had the right treatment in the end.

INT: AND THE PATIENT, HOW SATISFIED DO YOU THINK SHE WAS?

Doctor: Erm, I think difficult to, erm, difficult to assess. I think that she really wanted us to tell her what her treatment was and make the decision for her in the end, which we did.

INT: AT WHAT POINT DO YOU THINK YOU BECOME AWARE YOU'RE TALKING TO A PASSIVE DECISION MAKER?

Doctor: Erm, [chuckles] when you just don't get any feedback of what they want. Yeah, especially when you've spent ages talking to them and you're at square one really.

INT: AND DOES THAT AWARENESS CHANGE OR TAILOR HOW YOU APPROACH THAT PERSON?

Doctor: I think you have to make a decision at some stage that I'm going to have to decide what this patient is going to have, and you have to do that sooner or later so you'd be going on for weeks on end seeing this patient about trying to make a decision otherwise, so it gets to a point where you just have to say, 'Right, that's it, well I think this would be the best thing for you. What do you think about that? Do you agree with it?'

INT: THINKING ABOUT PATIENTS IN GENERAL WHEN YOU DIAGNOSE CANCER PATIENTS IN GENERAL FOR A SECOND, HOW SOON DO YOU THINK FROM HEARING THEIR DIAGNOSIS TO MAKING THE DECISION TO ACTUALLY WHAT OPERATION THEY'RE GOING TO HAVE, HOW LONG DO YOU THINK IT TAKES THEM TO MAKE A DECISION, JUST GENERALLY?

Doctor: Erm, I think it takes a little while. I don't think it's right to be trying to make that decision all on the initial diagnosis because I think they need some time, and I think it's quite good that we see them back in a week, or sometimes longer than that if, you know, there's reasons for them needing to come back even a fortnight or whatever, because they have had time to think and talk to their family, partner, all the rest of it. And you often see that when they come back on the second visit that they're much calmer and are able to talk about things sensibly whereas when they've just been given a cancer diagnosis it is very difficult to start going into details of what sort of surgery, and you've got different options and, you know, what do you want to have, so I think it is good we see them back.

INT: AND WE'VE BEEN TALKING ABOUT THREE DIFFERENT TYPES OF DECISION MAKER, ACTIVE, PASSIVE AND COLLABORATIVE, WHICH DO YOU THINK IS PERHAPS THE EASIER TYPE TO CONSULT WITH, IS THERE AN EASIER TYPE DO YOU THINK OR ...?

Doctor: Erm, well certainly the active, as long as we think that's a safe option, that, you know, they're nice and easy; it's when we don't think that their decision is the safe one it can be more difficult. And I think the collaborative decision makers are quite nice to work with because you feel that you've come to a mutual decision and you'll have that patient, that they they've made their own decision at the end of the day, so I quite like dealing with these patients. I think the passive can be difficult.

INT: LAST COUPLE OF QUESTIONS. THE LITERATURE TELLS US THAT THERE'S A VARIETY OF INFLUENCES ON PATIENTS MAKING DECISIONS ABOUT SURGICAL TREATMENT ...

\*Q20. THINKING FIRST OF ALL IN A WIDER SENSE, BEYOND THE UNIT, WHO OR WHAT DO YOU THINK HAS THE GREATEST INFLUENCE ON PATIENTS' DECISIONS ABOUT WHAT SURGICAL TREATMENT TO HAVE?

Doctor: Erm ... I think probably, certainly the more interested younger patients probably the media is quite a bit of influence, and, you know, if there's been some celebrity has had treatment or whatever, or, erm, there's quite a bit of breast cancer stuff in the news these days, you know, and again the different treatments and on the internet and so on, I think patients are more aware really.

\*Q21. AND THINKING WITHIN THE CONTEXT OF THE BREAST TEAM HERE, WHO OR WHAT DO YOU THINK HAS THE GREATEST INFLUENCE ON PATIENTS' DECISIONS ABOUT WHAT SURGICAL TREATMENT TO HAVE?

Doctor: Erm, I suppose it's going to be the people that see them in clinic, and probably the surgeons because it's the surgeon who talks about the treatment and I suppose, you know, the way that the consultation has gone and what's said to the patient, along with their personality and their expectations really, I would say.

INT: AND IF YOU HAD THE POWER AND MONEY TO CHANGE ONE THING ABOUT THE SYSTEM HERE, WHAT WOULD IT BE?

Doctor: That's a difficult question, isn't it? [chuckles] Erm ...

INT: OH WE KEEP THE HARD ONES TILL LAST.

Doctor: Ah, yeah, what can I say here? It would be nice to have more staff I think, just to sort of, to cope with the sheer numbers of patients, and so we're trying to do some reconstruction here now and that's a fairly new thing, but that's starting off doing quite well and we're working on that so it would be nice to, you know, to offer that more to the patients and just be able to have a bit more time really to spend with them, and the people available to do it. And the people to do the surgery. Again if you're going to do more reconstruction you need more time and you need more operating space for me - I could do more lists if there was more operating space - we haven't got enough theatres at the moment, and so on. So ... these things would be nice.

\*Q22. FINAL QUESTION, IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD TO WHAT WE HAVE BEEN TALKING ABOUT TODAY? ANYTHING YOU THINK WE'VE MISSED THAT'S IMPORTANT OR ANYTHING LIKE THAT?

Doctor: I don't think so. I think that two of my comments are for our high wide local rate here are, as number one I think we do tend to offer wide local to



larger tumours than some of the units; and number two I don't think some of the consultants always offer a, you know, true choice. Whether they're trying to change a bit now I don't know, but I'm sure there's other things as well, I'm sure that's not the only reasons, but that's what my personal feelings are.

[End of interview]