

*SURGICAL MANAGEMENT PREFERENCES STUDY: Interview (Nurse)

*VENUE: Low MR unit

*DATE:

*ID: BCN039

*INTERVIEWER: DJW

*Q1. HOW LONG HAVE YOU WORKED IN THIS BREAST UNIT AS A SPECIALIST BREAST NURSE?

Nurse: About five and a half years.

INT: FIVE AND A HALF YEARS, OK. AND SO, THINKING ABOUT THINGS LIKE YOUR LIKES, YOUR DISLIKES, THE UNIT PHILOSOPHY, THE DAY TO DAY RUNNING OF THE SERVICE, OK, THE UNIT IN GENERAL

*Q2. WHAT IS IT LIKE TO WORK AS A SPECIALIST NURSE IN THIS BREAST SERVICE?

Nurse: I haven't anything to compare against working in other breast units but I think it is pretty good, I think, erm, certainly we work as a good breast care team, a very supportive team, as well as a multidisciplinary sort of view, our feel our position has improved since I started. It could still improve somewhat but I think it's good.

INT: SO THINKING ABOUT THE ACTUAL STRUCTURE OF THE SERVICE WHEN PATIENTS SORT OF COME AND SORT OF ... CAN YOU GIVE ME A SORT OF THUMBNAIL SKETCH OF HOW A PATIENT WOULD GO THROUGH THE CLINIC, JUST VERY QUICKLY, YOU KNOW COMING IN TO START AND THEN WHEN THEY GO THROUGH THE CLINIC ...

Nurse: OK. Patient comes in, report to receptionist, take a seat then, depending on what's been said as their first sort of investigation, the clinic helpers will get them changed. If they're having a mammogram first they'll go off to the radiographers, have that done. If they're having ultrasound first they'll be taken into, erm, the ultrasound room and the breast care nurse would introduce themselves and take them, explain what's going to happen briefly. If they're having a clinical first, again the breast care nurse would come, introduce them, take them through to the doctor, erm, whatever tests they have done, that's explained to them why it's being done, information's given as to what's been found, erm, then if they're having to have more tests they would sit and wait for those, be called in, and, depending on what the tests that they have, what they show, they may be explained that, erm, nothing's been found, or explained what has been found and why no further action's needed, and discharged. Breast care nurse then reassures them, explains to them, see if they've got any questions, erm ... sends them on their way. If they are having needle tests that are going to need further appointments, again all that's explained by the doctor. The breast care nurse will then ensure that they understand, answer any questions, see that they're coping with what's been told so far, organise, go to the clinic reception with them, organise their appoint, and make sure they've got contact. If they have a problem, if they're diagnosed, obviously be in at time of diagnosis, erm, then when the consultant's gone, again check that the patient understands what's happened, answer their questions, give them information, sort out any tests that they need and organise an admission.

INT: OK. WE'RE GOING TO RETURN TO SOME OF THESE THINGS A LITTLE BIT LATER IN MORE DETAIL, BUT I LIKE TO GET A PICTURE IN MIND HOW THINGS ARE GOING. ERM, AND ABOUT THINGS LIKE TIME AFTER THE DOCTOR, I MEAN YOU'VE DESCRIBED SOME OF IT, I DON'T THINK YOU GUYS DO HOME VISIT HERE, DO YOU? IS THAT RIGHT, NO?

Nurse: We don't, NO.

INT: I'VE PICKED THAT UP FROM THE OTHER INTERVIEWS, AS WELL, YEAH. IS THERE ANYTHING HERE THAT YOU THINK MAKES YOUR JOB EASIER AS A BREAST CARE NURSE, REALLY SORT OF FACILITATES THAT PROCESS IF YOU LIKE?

Nurse: Erm ... there's the layout of the building and having ...

INT: IS THIS A NEWISH BUILDIKNG, LOOKS THAT WAY.

Nurse: Yeah, erm, it's about ... 1999? So it's getting on now, but relatively new. So the facilities that we have, the dedicated quiet rooms rather than having to talk to someone in the corridor or a grotty room somewhere in clinic or whatever. Good office facilities. Again I think the breast care nurses work well as a team. If one person is with a particularly, a patient who's not coping well, who you're going to have to spend some extra time with, the others will, you know, if you let them know, then obviously people are aware and can sort of cope and adjust. I think we just work well as team.

INT: OH THAT'S GOOD. AND THE OTHER SIDE OF THAT, IS THERE ANYTHING HERE THAT YOU THINK CONSTRAINS HOW YOU WORK AS A BREAST CARE NURSE? ANYTHING YOU THINK COULD BE BETTER?

Nurse: Sometimes the time that we have to spend with patients, erm, I mean not every clinic will you have your full complement of staff on, and you perhaps don't have the time that you feel that you need to give to somebody, but then you advise the patient that if they want to come back again at another time that's mutually convenient that can be arranged, but sometimes it's just pressure that you know you've got to sort of move on to the next patient sometimes when you just feel it would be nice, in an ideal world, ...

INT: YEAH. YOU'VE MENTIONED ABOUT THE TEAM GETTING ON VERY WELL TOGETHER, I MEAN YOU'VE BEEN HERE, ARE YOU ONE OF THE LONGER SERVING ...

Nurse: Yeah. Me and Sue.

INT: YEAH, NURSES HERE? SO I MEAN HOW WELL DO YOU GET ON WITH YOUR COLELAGUES IN GENERAL, I'M TALKING ABOUT THE NURSES AND THE CONSULTANTS AND THAT?

Nurse: Yeah, fine, well, mm, yeah. I think certainly some of the consultants are becoming a little more approachable than they used to be one time, you know, way back when, it was a kind of no-no, but are more open to ideas. Things are changing: things have changed.

INT: BEFORE THIS, BEFORE YOU BECAME A SPECIALIST NURSE, WERE YOU ON THE WARDS OR ...?

Nurse: I was a ward sister in a different hospital.

*Q3. DO YOU FEEL THAT PROFESSIONALS HAVE SORT OF DIFFERENT WAYS OF WORKING AND, IF SO, WHAT SORT OF THESE WAYS HAVE YOU SEEN WORKING HERE?

Nurse: Yes, they do have different ways. Erm ... how to describe them ... some would perhaps follow a more regimented sort of, you know what they're gonna say almost as they, every, they sort of have the same sort of routine each time. Others are a little more, more variant. Erm ... some appear a little more organised than others. [Pause] Some would ... how to explain it ... erm, I suppose some do, erm, sort of - I'm trying to sort of find the right words - erm ... not ...

INT: [???) SORRY, WERE YOU GOING TO SAY SOMETHING ELSE?

Nurse: Not, erm, sort of brusque and off-hand, but they're a bit more sort of ...

INT: TO THE POINT.

Nurse: ... to the point than others, some might be a little bit more, not relaxed or laid back, but sort of not as forthright with things, but at the same time being professional and sort of covering all the issues.

INT: YEAH, OF COURSE. IS THAT JUST THE CONSULTANT?

Nurse: Yes.

INT: WHAT ABOUT AMONGST THE BREAST CARE NURSES?

Nurse: Oh right, among the breast care nurses. Erm, ... I mean it's difficult to say exactly how the others work because you're usually working on your own in with patients. I mean how you people handling people on the phone, I think everybody does it in a similar manner.

INT: DO YOU TEND TO WORK WITH ONE PARTICULAR CONSULTANT OR DO YOU JUST, IS IT JUST WHOEVER CONSULTANT'S ON AT THE TIME OR ...?

Nurse: I tend to do, or, we perhaps have certain clinics that we tend to be in with a consultant with, erm, but then other clinics you may be with different people. So somebody would perhaps tend to do one consultant's clinic every Thursday afternoon, erm, and then the others would sort of vary between the other doctors in the clinic. Erm, somebody else would do the consultant on Friday, or whatever, erm, but there [???] people on holiday, study leave, so, so it does change.

INT: I'D LIKE TO MOVE ON NOW TO JUST BEFORE THE CONSULTATION BEGINS WHERE A DIAGNOSIS IS GOING TO BE GIVEN, AND I'D LIKE TO TALK ON, IN THIS POINT NOW ON JUST NEWLY-DIAGNOSED BREAST CANCER PATIENTS.

*Q4. WHEN IS YOUR REGULAR BREAST MDT HELD IN RELATION TO THE CLINIC WHERE PATIENTS ARE GOING TO BE GIVEN A DIAGNOSIS OF CANCER?

Nurse: MDT's on a Monday, Monday lunchtime, so it would be usually be the Monday before then.

INT: AND PATIENTS ARE DISCUSSED PRE-OPERATIVELY AT THAT MDT, IS THAT RIGH?

Nurse: Yeah, I don't attend that now since I went part-time, but certainly what from what I understand.

INT: HERE'S A QUESTION FOR YOU?

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

Nurse: I don't, I'm not there.

INT: OH, YOU'RE NOT THERE, OK. BUT YOU'VE BEEN THERE BEFORE?

Nurse: Yes, [???] How did I feel?

INT: HOW DID YOU USED TO FEEL?

Nurse: How did I feel? Erm ... I don't know if that's fair because, well ...

INT: HAVE THINGS CHANGED SIGNIFICANTLY SINCE THAT POINT [???] ?

Nurse: I think there are still discussions within the team and I mean it's hard to say what it is because I haven't actually been there now. Erm, before, I can only really comment on beforehand, erm, it may have been a bit dictatorial at times, and certainly the input from the breast care nurses was rarely called upon - occasionally but rarely. But certainly all the patients seemed to be covered and there was usually representatives from all members of the MDT and plans were [???].

INT: AND DO YOU THINK THAT, DO YOU THINK THAT CHANGED AT ALL, THINKING BACK THEN, DO YOU THINK THAT CHANGED AT ALL WHEN YOU HAD HEAVIER WORKLOADS OR LIGHTER WORKLOADS?

Nurse: Erm ... it was just sort carried, just plodded on through 'til it got to the end. I suppose people might have been a bit more stressed by it trying to make sure everybody got covered.

INT: MM. IT'S A BIT HARD I KNOW TRYING TO RECALL OTHER TIMES.

Nurse: Yes, it's quite a few years ago now [chuckles].

INT: IT'S JUST TO TRY AND GET, I MEAN IT'S NICE BECAUSE IT'S GOING TO GIVE A LITTLE BIT OF HISTORICAL PERSPECTIVE TO SORT OF THINGS, YOU KNOW, SO THAT'S QUITE INTERESTING ACTUALLY. SO, MOVING ON A BIT ...

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

Nurse: It varies on who is seeing them, depending on which doctor sees them as to whether they will give an indication as to whether they think there is a breast cancer there. Some do, some don't.

INT: THE ONES THAT DO, WHAT SORT OF THINGS WOULD THEY BE LIKELY TO SAY OR DO?

Nurse: That changes have been identified, they are worrying changes. 'We are suspicious this could be a breast cancer.' Those are the sort of ... 'Tests haven't confirmed it, that's why we need to have other tests, but it's a worrying change, it's a suspicious change.'

*Q7. IN WHAT WAY, IF ANY, DO YOU THINK PATIENTS THEMSELVES ARE LPREPARED FOR THE NEWS THEY HAVE GOT BREAST CANCER? I MEAN YOU'VE GOT, I KNOW YOU'VE GOT TWO DIFFERENT SETS OF PATIENTS SO YOU'VE GOT SCREENING PATIENTS AND YOU'VE GOT YOUR SYMPTOMATICS, THINKING I SUPPOSE FIRST ABOUT THE SCREENING PATIENTS AND THEN THE SYMPTOMATICS, WHAT DO YOU THINK?

Nurse: Perhaps in some cases they're a little, the screening actually, because we don't give any diagnoses at their first assessment visit, their, whatever needle test they would have to confirm diagnosis, they always come back the following week, so they've had that week where they know something's been found, they know they've had this needle test, obviously it depends what the doctor's said, if they've said it is suspicious or not. But they do get that week, however before that they didn't know there was a problem at all. So a lot of them I think have actually decided in their own head that they have got a breast cancer. Erm, some of the symptomatic ladies have gone to the GP with whatever problem, lump change, whatever, GP's said, 'Oh I don't really think it's anything but we'll send you up to the hospital just to be sore,' they have a test, they have a needle test, we have hot reporting and they're told there and

then, 'Yes, this is breast cancer.' So sometimes in actual fact it can be more of a ...

INT: AH, RIGHT, YEAH, MORE OF A SHOCK THEN.

Nurse: ... a shock for them. But, obviously, everybody's different and people react differently and some ladies in screening, because they didn't realise there was a problem, you know they haven't detected a problem, it's screen detected, it's a total bolt out of the blue. So ...

INT: THEY'VE KIND OF COME IN AS WELL WOMEN REALLY?

Nurse: Yeah, just sort of ...

*Q8. PRIOR TO A CONSULTATION WHERE YOU KNOW THAT A PATIENT WILL BE GIVEN A DIAGNOSIS OF BREAST CANCER, WHAT EXPECTATIONS MIGHT YOU HAVE ABOUT WHAT THE CONSULTATION'S GOING TO BE LIKE AND WHAT WOULD THEY BE BASED ON?

Nurse: Only expectations that the consultant will explain it to them and tell them what it is, talk to them treatment. I will not expect any, or have no pre-conceived ideas about their reaction to it because people are so different, and I would just be prepared to deal with however they react to it and assess as I go along if they're obviously very distraught by it and then the information that I would give them at that time would be as much as I felt they could cope with - I wouldn't throw everything at somebody if they were unable, if I felt they were unable to take it, whereas if somebody appeared to be coping well and was asking relevant questions and whatever, then I would be giving more information at that time as they needed it, whereas the other woman would perhaps be brought back and sort of followed up later on. So, erm, I mean expectation, as I say, that the diagnosis would be given, that the treatment would be discussed. It may be confirmed at that time, it may be that the person will come back and to sort of finally confirm that, but I will give them appropriate information, ensure that they've understood what's been said, erm, make sure they've got our contact details, deal with any questions, ensure they know how to get support if they need it. Is that ...?

[*Q9. HOW WOULD YOU DESCRIBE YOUR FEELINGS BEFORE SUCH A CONSULTATION? - not asked]

*Q10. CAN YOU JUST TALK ME THROUGH, WE'VE MENTIONED THIS BEFORE, BUT JUST IN A LITTLE BIT MORE DETAIL ABOUT THE CONSULTATION ITSELF, WHAT ACTUALLY HAPPENS IN A CONSULTATION WHERE DIAGNOSIS AND TREATMENT OPTIONS ARE BEING DISCUSSED WITH A PATIENT WITH BREAST CANCER. SO LIKE BASICALLY THEY'VE COME IN THE DOOR, WHAT USUALLY HAPPENS AFTER THAT THEN, JUST GENERALLY I'M TALKING ABOUT.

Nurse: Yeah. Doctor introduces himself and me initially, find out who, if there's a partner with them, who they are, [???]. Sort of go over 'You've had some tests from the previous week where you saw the other doctor,' and sort of go over what they found, and they usually would tell them what the specific test was that we were waiting for, whether it was a core biopsy, a needle aspiration, erm, and advise that that had shown a breast cancer or the DCIS, whatever the needle test has shown. With the DCIS they would then sort of explain what that actually means, perhaps draw diagrams, perhaps draw diagrams of the breast cancer if that's what it is. Then move on and tell them what needs to be done about it, obviously dependent on, I mean that could be surgery first, it could be chemotherapy, obviously it depends on the extent, that's not usually an issue, sort of in the screening patient that would usually be, needing sort of neo-adjuvant chemotherapy. So talk to them about surgery, explain what they felt was appropriate, different types of surgery, again draw them diagrams, asking the patient, sort of getting the patient to ask questions if they have any.

Talking about other treatments, talking about things the need for wide margins, erm ... sometimes they would, if the patient feels able to make a decision at that time, actually get out a date, explain when it would be done: if not, arranging for them to be seen again, organising further tests, erm ... and then if the patient hasn't got further questions, leave them with the breast care nurse and then I would ask them if they'd got any questions immediately from what the doctor has said to them and get them to explain to me what they understand by what's been said. Go through written information with them explaining what it says, what it actually means, again asking them if they've got questions. Organising the tests, also ensuring they've got support, know how to contact us. Explaining about admission, answering questions about that or arranging for an appointment to come, whichever appropriate.

INT: SO AT THE BEGINNING THEN YOU MENTIONED YOURSELF AND THE DOCTORS, IS THERE ANYBODY ELSE USUALLY IN THE ROOM?

Nurse: Patient, patient's relative, friend, support, whatever. There may be on occasion a medical student or there may be a student nurse or perhaps sort of a district nurse or nurse from the community that's spending time with us, but if, certainly if there is somebody with the breast care team, then we would always get the patient's permission before we actually talk to them and explain we have somebody with them, are they happy for that. But it's always done with medical staff.

INT: I'VE ONLY BEEN IN A COUPLE OF CONSULTATION PRIOR TO DOING THIS STUDY BUT I'D NEVER ACTUALLY BEEN IN A CONSULTATION ROOM, IT WAS QUITE, IT WAS QUITE AN INTERESTING EXPERIENCE.

Nurse: Yes, the best one was when I had a student nurse who actually fell asleep. [???] That was good.

INT: OOH, SORRY, YOU MENTIONED THINGS LIKE DIAGRAMS, DRAWINGS, IS THERE ANY OTHER TOOLS IN THINGS LIKE THE CONSULTATIONS THAT YOU ARE IN, IS THERE ANY PICTURES, X-RAYS, MAMMOGRAMS, ANYTHING LIKE THESE?

Nurse: They would show, potentially show them the mammograms, yes, ultrasounds, yeah.

INT: AND DO YOU THINK THAT, IS THERE ANY OF THESE SORT OF TOOLS LIKE YOU'VE USED, IS THERE ANY THE PATIENTS FIND PARTICULARLY HELPFUL MORE THAN OTHERS?

Nurse: I think it depends what the scenario is. If you're talking about, if a patient's got DCIS, actually showing them the mammogram of the little flecks of chalk can actually give, it's not something that they can perhaps understand, it's not so well-known as a lump or whatever, a true cancer, so that can perhaps give them a better understanding for what it is, especially if you're suggesting that a mastectomy may be the best option because it is so widespread, so you can actually see and explain why. But I think quite often sort of how they actually do hand-drawn pictures again gives an idea of where it is in the breast, what area they're going, what's going to be removed or whatever. And again mammograms because again, it depends how easy to actually see on a mammogram what the area is, but it helps them to visualise especially if they haven't known of it before.

INT: AND YOU MENTIONED EARLIER ABOUT CONSULTANTS, HOW THEY HAVE CERTAIN STYLES, HOW DO THEY THINGS AND WHAT-HAVE-YOU, CERTAIN APPROACHES, BUT YOURSELF, I MEAN, DO YOU HAVE A KIND OF PREFERRED APPROACH, SOMETHING YOU GO IN TO START WITH AND THEN ... HOW YOU THINK IT'S GONNA GO, SOMETHING YOU ALWAYS SAY WHEN YOU WENT IN?

Nurse: Well, I obviously introduce myself, and certainly if, once the consultant has gone, when it's just sort of left with myself and the patients, I always ask them, the first thing I'll say is 'Have you got any ...' well, erm, 'Have you got any questions immediately, is there anything you don't understand immediately from what the doctor said?' So I think, you know, if there's still lots of things sort of buzzing round they don't understand, sort of deal with those before I try and give them any other information.

INT: AND WHEN YOU'RE IN THE ROOM WITH THE PATIENT AFTER THE DOCTOR YOU SAY, THE CONSULTANT AND YOURSELF, WHAT KIND OF FEELINGS TO YOU HAVE TALKING ABOUT THESE KINDS OF ISSUES THAT YOU'RE DISCUSSING THERE?

Nurse: ... How do you mean?

INT: JUST SORT OF, YOU KNOW, I MEAN AFTERWARDS I SUPPOSE YOU'LL DO SOME KIND OF REFLECTION WHEN YOU COME OUT AND SEE HOW IT WENT AND THINGS LIKE THA, WHAT'S YOUR SORT OF GENERAL FEELING YOU TEND TO HAVE WHEN YOU'VE BEEN IN A CONSULTATION WITH SOMEONE?

Nurse: Erm, I suppose it depends how the patient's taken it. Obviously if they're very distressed it would tend to make you, you would feel for them. I mean not that you don't feel for the others but ...

INT: NO, OF COURSE.

Nurse: Erm ... if somebody ... I like to think I sort of come out and I feel sort of that I've done the best job that I can, that I've imparted information to the patient that they appear to be understanding what's been said and that you feel that, you know, you're helping them along the path that they're going. It varies so much from patient to patient depending on so many different factors, it's hard to sort of say you feel one particular ...

INT: YEAH. AN DURING CONSULTATIONS WHERE YOU'RE TALKING ABOUT DIAGNOSIS AND TREATMENT OPTIONS, WHO DO YOU THINK TENDS TO DO MORE OF THE TALKING, AND WHO DO YOU THINK TENDS TO ASK MOST OF THE QUESTIONS, JUST GENERALLY?

Nurse: You mean between the patient and ...

INT: THE PATIENT AND THE ... YOURSELF OR THE DOCTOR.

Nurse: Again it's very variable, you get some patients who're very passive and ask virtually no questions, and then you get some patients who have a million and one questions. Erm, I suppose on average probably the doctor or the nurse will impart more information than the patient would ask.

*Q11. CAN YOU TELL ME ABOUT ANY ADDITIONAL TIME YOU USUALLY HAVE WITH A PATIENT AFTER THE CONSULTATION, SO THEY'VE BEEN TO SEE YOU AND THEY'VE OBVIOUSLY LEFT THEN, AND YOU DON'T DO HOME VISITS, I KNOW THAT, WHAT ABOUT THINGS LIKE ANY OUTPATIENTS VISIT IMMEDIATELY AFTER THE DOCTOR, TELEPHONE CALL OR WHATEVER, PRE-ASSESSMENT CLINIC, SOMETHING?

Nurse: Yeah, we don't tend to see people on pre-assessment clinic unless the staff from there call us round if there's a particular problem or feel that we need to see somebody.

INT: IS THAT VERY COMMON DO YOU THINK OR ...?

Nurse: Does anybody ...?

INT: I'M SAYING IS THAT VERY COMMON DO YOU THINK?

Nurse: No, no, not very common. We make sure the patient has got a contact card for the breast care nurses and encourage them to use it, that we are here for them if they feel they need to talk to somebody before either their admission or their next clinic appointment. If somebody, as I say, was particularly distressed at diagnosis isn't able to take much information on board or just wants to get out of the Department, feels they can't cope at that time, then we would organise for them to come back, as I say organise a time for that. Sometimes if it's late in the day, erm, the tests that they would have, the staging tests can't be done because the other departments are closed, so we would organise for them to come back at that point, so we may meet them when they come back for those tests and sort of catch up with them if they want to talk to us. So ...

INT: WHAT KINDS OF, SORT OF THINGS MIGHT YOU DISCUSS WITH A PATIENT AT THOSE PARTICULAR TIMES?

Nurse: If they've come back?

INT: YEAH.

Nurse: Erm, I mean it depends, as I say, if a patient hasn't really, has just felt they've had to get out of the Department after diagnosis, can't take anything on board, it would be imparting again the information that the doctor had told them about surgery, about their condition, about treatments, giving them written information, erm, backing that up, answering whatever questions they may have obviously had time to sort of think of things that they want to ask. If it's somebody coming back, as I say, for the staging tests, it may be sort of questions that they have, more dealing with those rather than sort of going over into a lot of detailed information unless they, that arises from the questions.

INT: THINKING ABOUT PATIENTS JUST IN GENERAL NOW, FROM THE MOMENT THEY'VE BEEN TOLD THEIR DIAGNOSIS, THEY KNOW, THEY'VE BEEN TOLD THEY'VE GOT CANCER, TO THE POINT WHERE THEY'VE ACTUALLY DECIDED ON A TREATMENT, HOW LONG DO YOU THINK THAT PROCESS TAKES, JUST GENERALLY?

Nurse: ... As I say, some patients, erm, will actually make those decisions there and then during that initial consultation, so I'm talking minutes, whereas other patients will be given the information, they may sort of indicate, give an indication what sort of treatment they prefer, but then return to another clinic appointment and make the decision then, so it can be days or a week.

INT: I'D LIKE TO TALK A LITTLE BIT ABOUT PATIENTS' INFORMATION NEEDS.

*Q12. IN YOUR EXPERIENCE, WHAT DO PATIENTS TEND TO KNOW ABOUT BREAST CANCER AND ITS TREATMENT OPTIONS BEFORE THEY COME TO SEE YOU OR BEFORE THEY COME TO A CONSULTATION?

Nurse: Erm, most understand that surgery's involved and most people are aware that mastectomy is a type of surgery and people are aware now that conservative surgery is done, erm, people understand, well quite often are aware that chemotherapy's used and radiotherapy. Some people have heard of drugs like Tamoxafen and some people know of every weird and wonderful thing that's the latest research in America and they've come armed with everything off the internet, but that's a minority [chuckles] that are that well armed.

INT: DO YOU IF A PATIENT SORT OF KNOWS A LOT OR A PATIENT KNOWS A LITTLE, THESE SORT OF VARIABLES, ARE THEY HARDER OR EASIER CONSULTATIONS DO YOU THINK IF SOMEONE KNOWS A LOT OR A LITTLE? WHAT DO YOU THINK?

Nurse: Erm ... probably are those that are armed with everything off the internet are harder.

INT: MM, AND WHY DO YOU THINK THAT IS THEN? YOU KNEW I WAS GOING ASK THAT NEXT QUESTION ...

Nurse: Why? Erm ... they may be aware or they may have read about things that aren't necessarily relevant to them or are not [???] in this country or are still sort of undergoing research, so there's a lot more explanations as to why this isn't being done and why it's not done this way, or what it actually means. And they've perhaps sort of got their head round all these other things that they feel should be being done but ... those things aren't, it's not actually sort of standard practice or recognised practice. So trying to sort of undo that and what actually is sort of the treatments that are available. Whereas if somebody doesn't know, then obviously you can explain, advise them of the options that are relevant.

*Q13. WHAT DO YOU THINK ARE THE MOST IMPORTANT PIECES OF INFORMATION PATIENTS NEED OR WANT TO KNOW ABOUT THEIR DIAGNOSIS AND WHEN ARE THEY NORMALLY RAISED? JUST FROM LISTENING AND WHAT YOU'VE HEARD ...

Nurse: One of the things everybody wants to know is how long it's been there, but that's something that they as a patient want to know, erm, which is impossible to answer really. What they need to know? That it is a cancer, whether it is a cancer or a DCIS, the difference is obviously explained. And the most effective means of treating it, and if there are options what those options are and what each option entails, the pros and cons of each.

INT: AND WHEN YOU'RE DISCUSSING SORT OF JUST ISSUES LIKE TO DO WITH DIAGNOSIS, IS THERE ANY INFORMATION THAT PATIENTS PARTICULARLY UNDERSTAND WELL, ANYTHING THEY SORT OF, THEY DON'T REALLY HAVE TO ASK QUESTIONS ABOUT, IT'S KIND OF JUST GONE IN REALLY?

Nurse: ... That they need an operation probably, because I can't say that they understand it necessarily all the time immediately when they're told they've got cancer because people will then turn round and say, 'Is it, when will be know if it's benign or malignant?' so to say somebody's got a cancer they always don't take that on board. But certainly if you're telling somebody they need to have surgery, they need an operation, ...

INT: IS THERE ANY INFORMATION ABOUT DIAGNOSIS THEY UNDERSTAND POORLY, AND YOU REALLY HAVE TO SORT OF GO OVER AGAIN?

Nurse: I'd say in some cases confirming what a cancer, tumour, malignant, explaining the terminology. Erm ... it's hard to say because, you know, different people pick up different things and I can't think of anything that's sort of routinely poorly understood, off the top of my head.

INT: THAT'S OK. I'M GOING TO ASK A SIMILAR SORT OF QUESTION ABOUT SORT OF THEIR TREATMENT OPTIONS I SUPPOSE ... IS THERE ANYTHING ABOUT TREATMENT OPTIONS THAT PATIENTS UNDERSTAND PARTICULARLY WELL?

Nurse: Erm ... I'm not quite sure how to answer it. Erm ... thinking back on the last one about what they don't understand well, and sometimes that if you're sort of saying to somebody that, 'Yes, they're suitable to have conservative surgery but at the end of the day you have always got an option of mastectomy.'

INT: THE CHOICE.

Nurse: The choice, but that is often not grasped well.

INT: DO YOU KNOW WHY IT'S NOT GRASPED WELL.

Nurse: No. But I've noticed a few times that that, at the end of the day you always have a choice, you could still opt for a mastectomy, they've not [???] grasp that. What they understand well ...? Erm ...

INT: IT'S HARD TO WORK OUT WHAT PEOPLE UNDERSTAND WELL BECAUSE YOU DON'T NOTICE IT WHEN THEY'RE JUST [???] IT'S VERY DIFFICULT BUT IT'S SOMETHING THAT I'VE NEVER SEEN ASKED BEFORE SO WE DECIDED TO ACT THAT. I'VE OFTEN HEARD PEOPLE SAY, WHETHER OR NOT PEOPLE UNDERSTAND, THAT'S SO OBVIOUS BECAUSE THEY SORT OF [???] SAY, 'CAN YOU SAY AGAIN?' BUT IT'S WHAT PEOPLE UNDERSTAND WELL.

Nurse: I don't know, [???]

INT: IT'S OK, DON'T WORRY

*Q14. WHAT DO YOU THINK ARE THE MOST IMPORTANT PIECES OF INFORMATION PATIENTS NEED OR WANT TO KNOW ABOUT TREATMENT AND WHEN ARE THEY RAISED? [not asked]

INT: RIGHT, I'D LIKE TO MOVE ON A BIT NOW TO WHAT A PATIENT IS ACTUALLY OFFERED IN TERMS OF TREATMENT, WE'VE GOT A GREAT QUESTION HERE SO YOU HAVE TO LISTEN VERY CAREFULLY.

*Q15. WITHIN THE CONTEXT OF YOUR UNIT'S GUIDELINES AND PUBLISHED RESEARCH, PLEASE DESCRIBE THE FACTORS THAT WOULD LEAD YOUR TEAM TO OFFER A PATIENT...

*a. ONLY BREAST CONSERVATION SURGERY

Nurse: A small cancer, less than 4cm but obviously in relation to the size of the overall breast. Erm, unifocal, just one cancer; in the outer part of the breast. Patient choice. Not solely in the outer part of the breast but that would be an indication for it could be elsewhere [?].

*b. AND A SIMILAR SORT OF QUESTION HERE, WITHIN THE CONTEXT OF YOUR UNIT'S GUIDELINES AND RESEARCH, CAN YOU DESCRIBE THE FACTORS THAT WOULD LEAD YOUR TEAM TO OFFER ONLY A MASTECTOMY

Nurse: Large tumour, above 4cm although in relation to the overall size of the breast, centrally located, multifocal, if they've had previous wide local excision, radiotherapy [???] in the same breast. Patient [???], patient choice.

*c. AND WHAT WOULD LEAD YOUR TEAM TO OFFER A PATIENT A CHOICE BETWEEN THOSE TWO TREATMENTS, MASTECTOMY AND CONSERVATION?

Nurse: Obviously if a wide local excision, conservative surgery is suitable then, as I say, apart from when the tumour's sort of on the sort of outer part of the breast, then a mastectomy is an option. Whether or not that is made clear to all patients that are suitable for conservative patient is not necessarily always highlighted I think.

*d. AND WHAT WOULD LEAD THE TEAM TO OFFER A PATIENT OTHER TREATMENTS, THAT'S CHEMO, RADIOTHERAPY, THAT KIND OF STUFF?

Nurse: Yeah, er, if it was thought to be an inflammatory cancer, if it was an extremely large cancer or moderately large with lymph node involvement at diagnosis.

INT: THE LITERATURE SUGGESTS THAT PATIENTS VARY IN THE DEGREE OF INVOLVEMENT THEY WANT WITH MAKING DECISIONS ABOUT WHAT SURGERY TO HAVE: SOME PATIENTS WILL WANT FULL CONTROL OF THE DECISION PROCESS; SOME PREFER TO SHARE THAT CONTROL AND OTHERS'LL PREFER IT IF THE PROFESSIONALS TAKE FULL CONTROL. THAT'S KIND OF WHAT WE SPOKE ABOUT AT THE BEGINNING AS ACTIVE, PASSIVE, COLLABORATIVE PATIENT.

*Q16. DO YOU THINK PATIENTS ARE GETTING THE DEGREE OF CHOICE THEY WANT?

Nurse: You mean the patient themselves expresses a wish, their choice?

INT: YEAH, IF THEY ...

Nurse: Yeah, they express a preference then, yeah, as long as, erm, I mean, yeah, as far as it was deemed medically suitable. If there was, if somebody wanted a wide local excision and they had a 6cm tumour in the centre of the breast and they had an A cup, then they would be advised as to why not. But where it is, where it is suitable, then yes they are, yeah.

INT: OK. I'VE GOT A CARD TO SHOW YOU.

*Q17. THINKING ABOUT YOUR EXPERIENCES WITH PATIENTS THAT YOU SEE PLEASE LOOK AT THE RESPONSES ON THE CARD AND TELL ME, DURING CONSULTATIONS, WHO GENERALLY MAKES THE FINAL DECISION ABOUT WHAT SURGICAL TREATMENT TO HAVE? IF YOU CAN PICK ONE OF THOSE PLEASE.

Nurse: The patient ... is 'I' the breast care nurse or 'I' the surgeon?

INT: I WOULD SAY THE BREAST CARE NURSE ACTUALLY.

Nurse: Probably the second one, although I think more often than not they've probably already decided before.

INT: MM, SO WHICH IS GONNA BE, THE ...

Nurse: Patient tends to make the final decision about which treatment they will have after seriously considering my opinion.

INT: I'D LIKE TO TALK NOW A LITTLE BIT ABOUT COMMUNICATING WITH PATIENTS WHO HAVE A BREAST CANCER. THIS IS WHERE WE MENTIONED ABOUT THE ACTIVE, COLLABORATIVE AND PASSIVE PATIENTS. SO TAKE AS MUCH TIME AS YOU NEED ON THIS. AT THIS POINT I'D LIKE US TO THINK OR TALK ABOUT EXPERIENCES COMMUNICATING WITH PATIENTS. IN PARTICULAR I'D LIKE US TO FOCUS ON PATIENTS IN WHOM FOR CLINICAL REASONS MASTECTOMY IS NOT THE ONLY OPTION, YEAH?

Nurse: Not the only option?

INT: NOT THE ONLY OPTION. RESEARCH HAS IDENTIFIED PATIENTS WITH BREAST CANCER TEND TO FALL IN ONE OF THREE DIFFERENT DECISION MAKING CATEGORIES, IF YOU LIKE, THEY'RE ACTIVE, COLLABORATIVE AND PASIVE DECISION MAKERS. IN THIS FINAL SECTION OF THE INTERVIEW I'D LIKE TO ASK YOU A FEW QUESTIONS ABOUT HOW YOU FIND COMMUNICATION WITH EACH OF THESE TYPES OF PATIENT DURING THE CONSULTATION PROCESS THAT LEADS TO A FINAL TREATMENT DECISION. I'D LIKE TO START WITH SITUATIONS WITH ACTIVE DECISION MAKERS AND FOR THE PURPOSES OF THE STUDY WE DEFINE ACTIVE DECISION MAKERS AS PATIENTS WHO TEND TO MAKE THEIR OWN FINAL TREATMENT DECISIIONS EITHER WITH OR WITHOUR SERIOUSLY CONSIDERING THE SPECIALIST'S OPINIONS. OK?

*Q18. IF YOU CAN THINK FIRST OF ALL OF A SITUATION YOU HAVE HAD WITH A PATIENT WHO YOU THOUGHT WAS PARTICULAR ACTIVE ABOUT MAKING DECISIONS. PLEASE DON'T REVEAL ANY CONFIDENTIAL DETAILS ABOUT THEM, BUT CAN YOU TELL ME ABOUT YOUR

EXPERIENCE WITH THEM UP TO THE POINT WHEN THEY MADE A TREATMENT DECISION. DO YOU THINK YOU CAN THINK OF ANYBODY WHO WAS PARTICULARLY ACTIVE IN MAKING THEIR DECISION?

Nurse: Can that, could that include somebody who was making it actively but actively against medical opinion and to do nothing.

INT: YEAH, YEAH. ANYTHING THAT YOU THINK WAS PARTICULAR ACTIVE. IF YOU COULD THINK OF SOMEBODY KIND OF, TELL ME A LITTLE BIT ABOUT HOW THEY PRESENTED AND WHAT HAPPENED AFTERWARDS, THE STORY IF YOU LIKE.

Nurse: ... This one sort of springs to mind, this woman was very active in sort of her decision, but it, again, she was, erm, picked up on the screening programme, found to have a small area of DCIS, erm, she ... was adamant that she didn't want to have surgery. She felt that she would alter her lifestyle and her diet, erm, and although the explanations of what DCIS actually was, the implications of it at that stage, the implications if it was left, erm, the reasons why surgery was recommended, the possibility that there could be invasive cancer there already that just hadn't been detected, that all of these things were advised, she felt that she didn't need to undergo surgery and that she would change all these other things in her life and that was her treatment.

INT: RIGHT, OK.

Nurse: And then she presented, I'm not sure whether it was three or six months later with an invasive breast cancer and had surgery.

INT: OK. HOW DID YOU GET ON WITH THE PATIENT THEMSELVES?

Nurse: Erm ... I felt she was very set in her mind, she wasn't really listening to what we were saying and I felt that, my personal opinion was that she was misguided in what she wanted to do and her beliefs. And the consultant tried to advise her and give her the information and I reiterated that and tried to, well, basically just give her the information that she would hopefully make what I felt was the right decision. But she didn't, but, and I found it quite difficult that, erm, that she was probably doing herself harm, but at the end of the day that was her choice.

INT: HOW DID SHE GET ON WITH THE CONSULTANT?

Nurse: She seemed to get on OK, yeah, I mean she was, erm, she wasn't aggressive in her manner, she was just, sort of stuck to her guns really. The consultant was, certainly did his best, and listened to what she was saying, but advised her of his opinion. He dealt, I felt that they had dealt with it as well as they could.

INT: WHAT SORT OF INFLUENCE WAS APPARENT ON HER DECISION MAKING, DO YOU KNOW, [???) ?

Nurse: Erm, I'm just trying to think where, really where her ideas had originated from ... it's a little while ago. I honestly can't remember why she was so, why she had these, this particular viewpoint.

INT: WAS IT SOMETHING IN THE FAMILY SHE'D PICKED UP?

Nurse: I don't think it was her family, it was probably what she'd picked up in the media or something she'd read or ... sorry that's not very helpful. I can't ...

INT: NO, THAT'S FINE, THAT'S OK. I MEAN LOOKING BACK NOW, HOW SATISFIED DO YOU THINK YOU WERE WITH THE WHOLE EXPERIENCE WITH THIS PATIENT?

Nurse: Not.

INT: NOT AT ALL?

Nurse: No.

INT: WHY?

Nurse: Because our fears were, came to fruition, that by not accepting treatment she did herself more harm in the long run. But at the end of the day everybody has a choice as to what they do, and you can only impart information and if somebody doesn't want to accept it or doesn't want to do it you can't force them to. But it's ... you perhaps feel you haven't done, not that you haven't done your job because you can only go so far, as I say obviously you can't force somebody to do, but it's disappointing that you haven't been able to give what you would deem is the most appropriate treatment. But that's their choice.

INT: AND FROM THE OTHER SIDE OF THE COIN, HOW SATISFIED DO YOU THINK THE PATIENT WAS WITH THE EXPERIENCE? BECAUSE THIS IS A WOMAN WHO'S OBVIOUSLY MADE HER MIND UP, FOLLOWING HER OWN PATH.

Nurse: Yeah, I mean certainly at the time when it was decided she wasn't going to have, you know she'd decided she wasn't going to have surgery, and the surgeon said, 'OK, well that's your decision,' she seemed happy with that and pleased that it had, that was how it was left. I wasn't involved when she came back so I don't know how the perspective changes when she was actually diagnosed, but certainly at that initial she was happy with the way things worked, it was what she wanted.

INT: THINKING A BIT MORE NOW ABOUT ACTIVE DECISION MAKERS IN GENERAL, AT WHAT POINT DO YOU THINK YOU'RE AWARE THAT YOU'RE TALKING TO AN ACTIVE DECISION MAKER? I MEAN YOU MIGHT NOT THINK ABOUT THEM IN TERMS LIKE THAT IN YOUR DAY TO DAY PRACTICE, I UNDERSTAND, BUT JUST SORT OF, YOU KNOW, THINKING ABOUT IT NOW.

Nurse: Someone who act-, appears to ask relevant questions, that may tend to use some of the terminology that's sort of involved in and around the treatments, erm ... asking about different options, wanting to know about different things, about the treatment and what it involves, side effects of things. So the questioning, questions.

INT: AND WHEN YOU REALISE YOU'VE GOT SOMEONE WHO IS AGAIN YOU KNOW AN ACTIVE DECISION MAKER, ALTHOUGH YOU MIGHT NOT THINK ABOUT THEM IN THAT TERMS, DOES THAT AWARENESS SORT OF CHANGE HOW YOU ARE GOING TO, YOU KNOW, CONSULT WITH THAT PATIENT, HOW YOU'RE GONNA APPROACH THAT PATIENT?

Nurse: Erm ... not really because you're still going to, if sort of the things that they have questioned, you're still going to ensure that the information has all been given, that they're understanding things, but you get, you may get more of that back from them than you would if, you may have to not pursue it as far because it's obvious that it's coming back to you, as you would somebody who's passive that you would be having to try and get stuff out of. Erm ... I'm just trying to think in what aspect you would treat them differently ... obviously if somebody's asking more detailed questioned, you'd just think they had a heightened degree of understand you perhaps, your answers may be slightly different or more technical, then having to clarify that they do then understand that back [???] they don't really understand it.

INT: I'D LIKE YOU TO THINK ABOUT A SITUATION NOW WITH COLLABORATIVE DECISION MAKERS AND FOR THE PURPOSES OF THE STUDY WE DEFINE COLLABORATIVE DECISION MAKERS HERE AS PATIENTS WHO TEND TO SHARE FINAL TREATMENT DECISIONS WITH THEIR SPECIALISTS.

*Q19. AGAIN, SIMILAR TO WHAT WE'VE DONE, I WOULD LIKE YOU TO THINK ABOUT A PATIENT WHO YOU THOUGHT WAS PARTICULARLY COLLABORATIVE ABOUT MAKING DECISIONS, IF YOU CAN OF COURSE. AND WITHOUT AGAIN REVEALING ANY CONFIDENTIAL DETAILS, TELL ME ABOUT YOUR EXPERIENCE WITH THEM UP TO THE POINT WHEN THEY MADE A DECISION WHAT TREATMENT TO HAVE. I ACTUALLY FIND THIS IS THE HARDEST ONE. I ALWAYS HAVE A PROBLEM GETTING MY HEAD AROUND WHO WAS COLLABORATIVE. CAN YOU THINK OF ANYBODY?

Nurse: ... I can't think of any

INT: YOU CAN'T THINK OF ANYBODY IN PARTICULAR WE COULD TALK A LITTLE BIT ABOUT I SUPPOSE COLLABORATIVES IN GENERAL. WHEN YOU SORT OF, WHEN YOU'VE GOT A COLLABORATIVE PATIENT, HOW SOON DO YOU THINK YOU KNOW YOU'RE TALKING TO SOMEONE WHO'S A COLLABORATIVE PATIENT? WHAT'S SORT OF THE INDICATORS THAT THIS PERSON IS BEING COLLABORATIVE IN THE SENSE THAT WE'VE DEFINED?

Nurse: Can I have the definition again, please?

INT: YEAH, IT'S PATIENTS WHO TEND TO SHARE FINAL TREATMENT DECISION RESPONSIBILITIES WITH THEIR SPECIALIST, OR SPECIALISTS.

Nurse: ... I guess ... they're asking questions but they're keen to know the opinion of the doctor or that they may have a particular option that they favour but want support from the doctor, asking for their, how they feel about it, if they feel it is appropriate, how they ... is it possible to do it like that, sort of getting back-up from them. So of questions sort of [???

INT: AND HOW DO YOU FEEL ABOUT CONSULTING WITH COLLABORATIVE STYLE PATIENTS, DO YOU THINK THEY'RE EASY TO CONSULT WITH, DO YOU THINK THEY'RE DIFFICULT OR ...?

Nurse: ... Erm ... I don't think I've found them particularly difficult or not one extreme or the other really that I can try and think of.

INT: I THINK THAT'S WHY THEY'RE SO DIFFICULT REALLY. THESE PEOPLE TEND NOT TO STAND OUT I DON'T THINK. YOU KNOW, YOU ALWAYS KNOW IF YOU GET SOMEBODY VERY PASSIVE; YOU ALWAYS KNOW IF IT'S SOMEBODY ACTIVE, BUT WHEN YOU'VE GOT SOMEONE WHO'S KIND OF THE MIDDLE IT'S ALMOST LIKE THEY JUST KIND OF, IT'S A BIT LIKE THE QUESTION WHERE WE SAY DO YOU KNOW ANYTHING ABOUT THE THING THAT'S UNDERSTOOD WELL, YOU DON'T TEND TO NOTICE THAT. IT'S OK. I'D LIKE TO MOVE ON TO THE THIRD CATEGORY WHICH IS PASSIVE DECISION MAKERS. FOR THE PURPOSES OF THE STUDY WE DEFINE PASSIVE DECISION MAKERS AS PATIENTS WHO WANT TO LEAVE THEIR FINAL TREATMENT DECISIONS TO THEIR SPECIALISTS, EITHER WITH OR WITHOUT CONSIDERING THEIR OPINION.

*Q20. IN THIS SECTION I WOULD LIKE YOU TO THINK AGAIN ABOUT A PATIENT WHO YOU MIGHT THINK WAS PARTICULARLY PASSIVE ABOUT MAKING DECISIONS, AND, WITHOUT REVEALING ANY CONFIDENTIAL DETAILS, TELL ME ABOUT YOUR EXPERIENCE WITH THEM UP TO THE POINT WHERE A FINAL TREATMENT DECISION WAS MADE. IS THERE ANYBODY YOU CAN THINK OF ...

Nurse: I can't think of any one particular person off the top of my head but I can think of being in with various patients that I can't think of the full story ...

INT: THE FULL STORY, NO, THAT'S FINE.

Nurse: ... but certainly of that ...

INT: TELL ME A BIT ABOUT YOUR EXPERIENCES WITH THEM, YOU KNOW, IN GENERAL.

Nurse: Erm, I mean more often than not they probably are elderly patients and they come from that era where the doctor knows best and you don't ask questions, you do as the doctor tells you. And where they're given a choice, erm, they 'Oh, no, you're the doctor, you decide, you know what's best,' they don't want to take any part in the process, they just want it decided for them. They've come in, they've been told they've got a cancer and they want to be told what to do. And by making them, or trying to get them to think about the different aspects of it, they find that difficult.

INT: HOW DO THE CONSULTANTS REACT TO THIS?

Nurse: Erm, I mean certainly in some cases they say, 'Well, you know, it is your, it is up to you, you know, you have to sort of decide what you ... ultimately ...' some of them, on occasion some may say, 'Well I think x is best' and 'OK, that's fine, we'll do that then.' So ...

INT: AND YOURSELF, WHEN YOU'RE CONSULTING WITH THEM AFTER THE DOCTOR, HOW DO YOU FEEL THINGS GO WITH THEM?

Nurse: I just try to make sure they understand the implications of what they've, what is being done. For example, especially with the, in the case of conservative surgery where there is the possibility that they might need another operation if the margins aren't clear, I want to be sure that they understand that and they are fully aware of that. And probably would again, you know, point out that, you know, there is a choice, but try to ascertain that they are comfortable with what they've done and know what the implications of that particular choice or that decision are.

INT: IS THERE ANY PARTICULAR INFLUENCES DO YOU FIND WITH THESE PARTICULAR TYPE OF PATIENTS, THESE DECISION MAKERS?

Nurse: It may be the relative that's with them, they may have particular views. Erm ... is that what you mean, sort of influences?

INT: YES, ANY INFLUENCES YOU SEE ON THESE SORT OF PARTICULAR TYPE OF PEOPLE.

Nurse: Yeah, I mean, maybe their preconceptions, what they're understanding of it was, or as I say that their of an era when it was the doctor that decided and they haven't moved out of that [???].

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

Nurse: Well when they say, 'Oh, it's up to you, doctor,' or 'You decide, it's your decision, you're the doctor, you know best,' when they say something along those lines.

INT: AND DOES THAT SORT OF AWARENESS CHANGE YOUR APPROACH TO THE PERSON IN ANY WAY, HOW YOU'RE GOING TO CONSULT WITH THEM LATER?

Nurse: Yeah, erm, as I say I just try to reiterate what that operation entails, the implications of it, erm ... so that they are, they do understand what is happening or potentially could happen. But being aware that they're accepting whatever that is. Mm.

INT: I'D LIKE TO FINISH OFF WITH A COUPLE OF QUESTIONS. THE LITERATURE TELLS US THERE ARE A VARIETY OF INFLUENCES ON PATIENTS MAKING DECISIONS ABOUT SURGICAL TREATMENTS.

*Q21. THINKING FIRST OF ALL IN A WIDER SENSE, SORT OF BEYOND THE UNIT SORT OF THING, WHO OR WHAT DO YOU THINK HAS THE GREATEST INFLUENCE ON PATIENTS' DECISIONS ABOUT WHAT SURGICAL TREATMENT TO HAVE?

Nurse: The media ... in all shapes and forms, be it in the form of a magazine or the ... morning TV or soap stars [chuckles].

*Q22. AND THINKING ABOUT, YOU KNOW, WITHIN THE CONTEXT OF THE BREAST TEAM HERE, WHO DO YOU THINK OR WHAT HAS THE GREATEST INFLUENCE ON PATIENTS' DECISIONS ABOUT WHAT SURGICAL TREATMENT TO HAVE?

Nurse: It's what the doctor tells them.

INT: I'VE GOT ONE MORE LAST QUESTION. IF YOU HAD THE MONEY AND POWER TO CHANGE ONE THING ABOUT THE SYSTEM HERE, JUST ONE, WHAT DO YOU THINK IT WOULD BE?

Nurse: More staff.

INT: WHICH ONES THOUGH?

Nurse: Across the board.

INT: AH, RIGHT, OK.

Nurse: Every department.

*Q23. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD TO WHAT WE HAVE BEEN TALKING ABOUT TODAY? ANY QUESTIONS YOU'D LIKE TO ASK.

Nurse: No [?]

INT: OK.

[End of interview]

*Q24. THE REST OF THE TAPE HERE...
Here