**How are genetic tests transforming cancer prevention?**

**The G word transcript**

**Amanda: Hello and welcome to The G Word. My name is Amanda Pichini and I’m the Clinical Lead for Genetic Counselling at Genomics England. We know that cancer is a very common disease. About one in two people will develop cancer at some point in their lifetime. Cancer is a disease of the genome involving many changes to a person’s genome over time as well as other factors. Only a small proportion of all cancers are inherited, but this can have a significant impact for those families who have a much higher risk of cancer and options to reduce their risk.**

**Today I’m delighted to be joined by Dr Helen Hanson, Consultant Clinical Geneticist; Kelly Kohut, Consultant Genetic Counsellor; and Rochelle Gold, Patient Representative and co-founder of BRCA Journey. We’ll be discussing the CanGene-CanVar programme which aims to link NHS clinical care and research to expand access to genetic testing and care for people with inherited cancers. Welcome, Rochelle, Helen and Kelly to The G Word. Thank you for joining me today. Let’s start with some introductions. Rochelle, over to you?**

Rochelle: Hi, everyone. I’m Rochelle and I’m one of the Patient Reps on the CanGene-CanVar research programme. I also co-founded an organisation called BRCA Journey that helps to raise awareness of the BRCA genetic mutation amongst both clinicians and the community, and also supports people who might be at risk of the mutation or who are thinking about testing, all the way through to maybe having preventative treatment or preventative surgery. We support those with that decisions. We’re not genetic counsellors but we do basically talk to people about our experience and knowledge that we have of what it’s like as a patient to be someone living with the mutation.

**Amanda: Thank you. Could you briefly tell us what BRCA is and how you came to be a patient?**

Rochelle: BRCA is a genetic mutation that puts people at greater risk of breast and ovarian cancer. My mum had the mutation, in fact she had two of the mutations which is apparently quite rare. She passed away from breast cancer and just before she passed away I found out that I had the genetic mutation as well. I personally have had preventative surgery and reconstruction to prevent myself from getting breast and ovarian cancer. I got involved in being a patient rep so that I can advocate for people who may have the mutation, but also make sure that as many people as possible can be tested and be aware that they have the mutation and have that power to have the knowledge to be able to do something about it should they so wish.

**Amanda: Thank you so much for sharing that with us. Kelly, over to you?**

Kelly: Hello, everyone. I’m Kelly Kohut, I’m the Lead Consultant Genetic Counsellor at the South West Thames Centre for Genomics, which is based at St George’s Hospital in London. For many years I’ve been working in clinical practice in genetic counselling, seeing patients and their families regarding personal or family history of cancer, offering genetic testing where that’s available, and then giving the results and helping to refer people on for surveillance programmes and to discuss risk reducing options, and also help a lot with communication within families, sharing the information from the genetic test results.

For the past few years, I’ve also been doing my own research as part of the CanGene-CanVar programme, funded by the charity Cancer Research UK. This has involved partnering directly with patients and other expert stakeholders to co-design a patient website to support decision-making around the genetic chances of getting cancer in families.

**Amanda: Thank you. And Helen?**

Helen: Hi, everyone. I’m Helen Hanson, I’m a Consultant in Cancer Genetics. I’m based at the Peninsular Regional Genetic Service which is in Exeter. In my clinical practice I see patients who either have a cancer diagnosis to consider whether they may have an inherited susceptibility or people who maybe have a family history of cancer to try and determine if they are at risk due to their family history. Like Kelly and Rochelle I’ve also been involved in the CanGene-CanVar programme for the last four years. I’ve been involved in work package three of the programme which is developing clinical guidelines with the patients who have an inherited predisposition to cancer. I was also fortunate enough to be given some funding to carry on with this work beyond the programme in the new NIHR Exeter Biomedical Research Centre.

Also, I’m currently chair of the UK Cancer Genetics Group, who has an aim of improving the management of patients who have an inherited predisposition to cancer. It’s been really great to work on all these different things and try and bring things together to try and improve care for patients who do have rare inherited genetic conditions predisposing to cancer.

**Amanda: Fantastic. Thanks, everyone. Kelly, I wondered if you could start us off by just explaining a little bit more about how genetics and genomics is relevant to cancer. Especially inherited cancers, why is this an important thing to talk about?**

Kelly: The availability of genetic testing has been increasing steadily over the years. Currently from pretty much anyone who’s been diagnosed with cancer there should be some awareness around the possible benefit of knowing the genetics behind the development of that cancer and whether any genetic or genomic testing might help to choose more personalised treatments or surgical options for that cancer that’s been diagnosed. There is also the possibility of finding out genetic information that’s familial or inherited, which could mean that the information is not only important for the person who is being treated for cancer at the current time but also as a next step informing relatives that they might have a higher chance of getting cancers in the future due to a genetic variant and that they could ask their GP for referral to genetics to be offered genetic testing and to find out about their chances of getting cancer and the choices for how to manage that.

**Amanda: Thank you. There are clearly some important things that someone would do differently when they know they have an inherited cancer. Helen, how can we make sure that clinicians and patients and families know what do to in these situations?**

Helen: Following on from Kelly explaining the amount of genetic testing we can offer has really increased over the last five to ten years and we’re not in a position to offer many more patients genetic testing, it’s important that we also consider what to do with that information when we discover somebody does have a pathogenic variant or a mutation in a cancer predisposition gene. There are over 100 different cancer predisposition genes described and actually having a variant in one these genes is rare. It’s difficult and like other conditions in medicine due to their rarity to really understand how best to manage these patients. But what’s very important is that we try to understand how best we can help patients manage their cancer risk based on the lifetime risk of cancer and the particular cancers that they can develop and ensure that patients across the country are all being given the same advice, the same information about their cancer risks.

Through the CanGene-CanVar programme we’ve had a whole work package which is devoted to clinical guideline development where we’ve looked at a number of these genes and looked at the evidence that is available in terms of cancer risks, the utility of surveillance or early detection of cancers in that condition, and also whether risk-reducing surgery could be offered. Really try to bring together groups of experts to discuss the evidence because for some genes it really is quite limited due to the rarity of the condition. The overarching aim is really to develop guidance that is relevant and can be offered in our current clinical practice and is consistent to all patients who have a variant in one of these genes.

**Amanda: You mentioned that many of these inherited cancer conditions are very rare. Is there a need to look internationally or collaborate internationally? How do you pull some of these things together when there’s so little information?**

Helen: We definitely have found it really helpful to have international collaborations. Some of these conditions there may be very few patients in the UK who have this condition, so each individual clinician who works in cancer genetics may have only seen one or two patients with the condition than themselves and, therefore, collaborating with international colleagues has been very helpful and we have recently published some guidance for a condition BAP1 tumour predisposition syndrome which increases an individual’s lifetime risk of developing mesothelioma, which is a type of lung cancer, renal cancer and melanomas of the skin and eye. This is a rare condition, but we worked with European colleagues to develop a set of guidelines advising what surveillance the patient should have, so looking to melanomas, looking for early detection of kidney cancers, so having that international collaboration has been really very helpful because in the UK there are so few cases per centre of individuals who have that condition.

**Amanda: That sounds really helpful. Rochelle, we know that shared decision-making is so important in healthcare. How can we make sure that the voices of patients are reflected within these guidelines that were developing and that it’s clear to them what needs to happen for their healthcare?**

Rochelle: I think it’s really important that patients are involved in the development of the guidelines, first of all, and actually within those guidelines there is stuff that talks about that, being about shared decision-making. A lot of these guidelines are in a language that are quite a clinical language that is not necessarily accessible to patients themselves. It’s really important that they’re part of the creation of them but also that there are things out there that enable people to understand what are these guidelines about, what do these guidelines actually mean in practice. When you find out that you have a particular genetic mutation, of course, the first place you probably go is Google. You find a hell of a lot of information and you find all sorts from different countries and different people and different organisations. You’re like which is the thing I need to look at, which is the thing that actually tells me what’s going on, which is the thing that really helps me to understand what this actually means for me and what should happen to me? What is the pathway for me, etc.

I think we also need to recognise that people have different levels of health literacy as well. I am someone who can probably navigate my way around a very complex system, which is the NHS, maybe better than other people. But there are plenty of people out there who this is new people, this is a completely new thing that’s happened to them, a completely new thing to understand. If you’re not used to being part of health systems and navigating your way around it, it can be quite scary. What does mutation mean? What does it mean for me? What does it mean to my future? What does it mean for my family? All this information. There needs to be something somewhere that talks about this, some sort of lay way and helps people to understand what this means for them and helps them to engage with it. To some extent, that’s where my organisation was born from, that thing about having somebody who can just talk about it in normal words, in normal terms and normal views of what these guidelines actually do mean. The fact is they are just guidelines, they don’t tell you this is what you do. You’re this person, you’re in this circumstance, you do this, it doesn’t. There’s some ambiguity there that needs to be navigated by the patient and they need support in order to do that.

**Amanda: That’s a great point. Having previously worked as a genetic counsellor, also seeing patients with inherited cancer conditions, it really strikes you how individual each person’s journey and decisions are. They’re thinking about all kinds of factors in their life or in their family’s life. Navigating through that and understanding do I have surgery or do I have screening and how do I make decisions about this is based on my previous experiences and so many other factors. Having access to different sources of support to help people navigate through that feels incredibly important.**

**We’ve been talking a bit about inherited cancers in general, but you’re all here because you’re involved in the CanGene-CanVar programme. Kelly, could you tell us a bit more about what that is and what he programme is aiming to achieve?**

Kelly: The CanGene-CanVar programme is a five year grant funded by Cancer Research UK. It involves six different work packages, so lots of experts all around the UK have been allowed to have some dedicated time to work on specific areas where there hasn’t been enough resource put in in the past which has resulted in a real gap between the research and the current findings and actually using that information to benefit patients by bridging the gap and putting those research findings into clinical care.

My programme is in work package four which is co-designing patient resources which are decision support interventions. Basically, it’s a website and it can be printed as a booklet and it’s interactive and it’s up to date and it’s personalised to help convey the complicated information about genetic cancer conditions in a way that’s meaningful and patients can understand, and it helps them with their personalised shared decision-making. The CanGene-CanVar programme is underpinned by the patient reference panel and they’ve been involved, including Rochelle and others, from the conception of the idea of the programme and all the way through with various different activities helping to look at documents as they’re developed, before their finalised, and giving input in focus groups and one-on-one and email conversations. They’re called upon frequently to share their lived experience and say what’s important to them when they make decisions and that’s really helped to drive the direction of the research and inform the results before they’re published.

**Amanda: That sounds like a really helpful approach to developing something in a way that’s really working very closely with patients and participants. Rochelle, it sounded like you were involved in that. Can you tell us a bit about what that was like from your perspective?**

Rochelle: It’s really rewarding, it’s really motivating to be actually one of the patient reps in relation to this. I don’t want to make my colleagues from the team blush, but it’s just such an inclusive environment where as a patient is really welcomed, really heard, it’s very much a partnership and that’s been really, really important and it makes you feel valued as a patient and actually the importance of the lived experience the patient view has really been prominent in this. I would say that’s why it’s helped develop such a useful tool, the fact as a patient people are really valuing and taking into account our lived experience, our views, our understanding. It’s been quite fun in some of the sessions. There have been some good debates between us and some of the clinicians and it’s been really good and really useful. I think some of the people who maybe haven’t encountered a patient panel before and engaged with patient’s lived experience have probably learn a lot from it because we are pretty empowered to use our voice in this. It’s been a really great experience.

**Amanda: I’d love to dig into those debates a bit more. Kelly, were there things that you changed in the decision aid as a result of some of those discussions or as a result of that input that maybe surprised you?**

Kelly: We have made changes based directly on what we’ve learned from the patients presenting their lived experiences. They’ve been very open and honest with us. Like Rochelle, I felt so privileged to be part of this real partnership with the patients. As a genetic counsellor who had many years of experience in clinical practice before moving into this research role, I’ve been really surprised but also gratified by how much I’ve been able to learn from the patients in a different way because I am sort of taking a step back, I’m there as a researcher and not directly as a clinician looking after someone one-on-one in clinic and just thinking about their specific needs at that time. But because I’m hearing from people from all different situations, different parts of the UK and other countries and maybe it’s 10/20 years since they had their genetic diagnosis are actually getting a bigger picture of their care needs that we might not have heard about as the clinicians on the ground because they might not be coming back to tell us. If we haven’t opened the door to that conversation about their personal situation or who’s influencing them or what’s important to them when they make decisions, we just might not have learned about the thing they’re grappling with and they’ve gone off and maybe Googled, they’ve found a patient support group or something else to support them.

In my research and in my interviews and the focus groups, all of the activities I’ve been learning about the gaps in care, what might be needed to address that. The decision aid has not been yet ruled into clinical practice but we’re very keen to get it out there and everyone wants it and wants to use it. We want to make sure that we’ve developed it in a robust patient-centred way as much as we can for us before we put it out. It will always be updated and go through refinements, but hopefully in the New Year we will be able to let people start using it in the real world situation.

**Amanda: That’s great, I’m sure you’re looking forward to that.**

Helen: I was just going to add to that in terms of the guideline development we’ve had a number of consensus meetings where we’ve made decisions about guidelines, for example, genes that can be predisposed to ovarian cancer and we’ve included patients from the patient reference panel and from other patient groups in those consensus meetings. Again, as Kelly said, that’s been so helpful because it’s really brought something to those discussions and it is a different perspective than when we see patients in clinic because often we’re seeing them at the point of genetic testing or maybe for their results, but actually that doesn’t give us that overview of the whole patient journey and the whole patient experience. I think that has been really one of the benefits of this programme and Kelly has been really pioneering the co-design of patient information leaflets, decision aids with patients. Rather than clinicians designing things for patients that we think that they will understand, it’s actually working with patients from the start to get things right the first time. It’s been a really great part of this programme.

**Amanda: Rochelle, did you want to add something further here?**

Rochelle: Yes. I think one of the sessions that we had as a patient and clinician and researcher session that really stood out for me was when we started looking at how do people make decisions. We had academics and researchers who’ve looked at how do people make decisions, talk about the knowledge base and the research base that we have about it. As a larger group of patients we got together to discuss about how have we made decisions. It was really interesting because I don’t think I’ve ever reflected on how I made the decision and what came from that in terms of what I did about having my mutation. Hearing about how other people did as well, that session really does stick in my mind and actually I learnt a lot as a person about decision-making theory but also about myself and reflecting on how I make decisions. So as a patient involved in this, it’s not always about what I bring to this but actually as a patient rep you get a lot from it, too. I’ve learnt a lot from the colleagues that I’ve worked with.

**Amanda: That’s fantastic. It’s really great to hear the careful thought that’s gone into this, a real excellent example that hopefully others can look to. I think, Kelly, hasn’t your work won an award recently as well?**

Kelly: We as a whole team won an award from the academic health science network and the NHS Confederation, it’s called the Innovate Awards 2023. This was for excellence in patient and public involvement in transformation and innovation. Yes, it was a chance to showcase the really positive experience that we’ve had. I think on all sides we’ve learnt a lot from each other and just to hope to inspire other researchers and clinicians to take this co-design approach with patients because we all benefit from it so much. We think that the resources, the guidelines, everything that we develop will be better from the start if we work together throughout the project.

We’re really hoping to encourage others to consider from the beginning of their idea about a research programme or clinical development to bring the patients in right at the start, because they can really help to guide where things go next and then throughout. Even through to publications being on, committees, being co-chairs, presenting together at conferences, that can all help to really share the experience and the benefits that we get from the partnership.

**Amanda: That’s great, congratulations. Coming back now to some of the aims of CanGene-CanVar and trying to bridge that gap, as you said, between research and clinical care, I guess that means there are some needs that still aren’t being met that are falling through that gap at the moment. Helen, from your perspective what are some of those unmet needs that we currently have or areas that are still needing improvement?**

Helen: I think there’s still lots that we have to learn, particularly about individual risks for patients. We might have patients who all have a pathogenic variant in a certain gene but their risks might be slightly different due to factors that can modify their risk. Trying to understand some of those risks better so that we can really have much better informed discussions with patients about their lifetime cancer risks I think would be really helpful. Work package one of the programme is really focussing on that and looking at some of the information we have through national registries and trying to understand risks for specific genes better, which will help our discussions with patients, and then we still need to understand, which is more outside the programme, more how surveillance, so early cancer detection through screenings such as mammograms or ultrasounds for different cancers can help detect cancers early. There’s still lots of information that we need to learn.

I think Kelly’s decision aid which has been focussed on Lynch Syndrome, I think that can be translated across lots of other genetic conditions, because for each gene there is a different set of decisions. For some of the genes that we developed clinical guidelines for we might be recommending slightly different management or for some of the genes we’ve recommended maybe a minimum and an extended level of surveillance, particularly for a gene called DICER1 where we’ve offered different options in childhood. Decision aids would potentially help in some of those other genes building on the work that’s already been developed as part of the programme. Although the programme is coming to an end in the next year, I think there’s still lots of work to be done in this area.

**Amanda: It really sounds like you’ve all been collectively improving how much this work is worthwhile, so that’s great to hear. Rochelle, how about for you, are there areas that you would see as unmet needs or areas where we or research can improve to help patients and families with inherited cancers.**

Rochelle: Similar to some of the stuff that Helen was saying, knowing more about what happens when people have different types of treatment, different types of surveillance and monitoring and stuff like that, I think there are things that are evolving all the time. I think in the end when you think about gaps, there’s nothing that’s going to be written down on paper that says if you have this, do this. In the end, every single patient is an individual with individual circumstances. I think until we actually know that if you do this, this happens and this happens, this is going to be your chances of survival if you go through this route. Even then when you’ve got the chance of survival, that’s literally just a probability, it’s not a binary this will happen or that will happen. There’s always going to be a need for discussion, there’s always going to be a need for these brilliant genetic counsellors that we have to talk us through some of those complex decisions that we have to make. I think, yes, we’ll get more information, we’ll get more evidence, we’ll get more understanding of treatments that work best for different people, and we’ll get it out there and we absolutely do need to do that.

Even when you have all the information you need, even if you made a solid decision, I mean, when I found out I had the mutation immediately I was like, right, that’s it, I’ll have preventative surgery after what happened to my mum. It was an absolute no-brainer for me. For other people it might not have been if they were at a different life stage. I’d had my kids, I didn’t need my ovaries, I didn’t need my womb, it was pretty clear cut. Even then when I was thinking about the different treatment and when to have that surgery, I got most of my information from bumping into somebody in the ladies’ toilets who has been through it before. I think there’s always going to be a need in terms of being able to have those conversations to take in all the information you do that and make some sort of informed decision. What came out of that decision-making workshop and all the other things that we did about probabilities, it’s all just a model. It’s a model of what might happen. The thing is, all of these models, they’re all wrong, they just help you maybe make a discussion or a decision that might be right. You just never know. I still don’t know if the decisions I made were the right decisions either. There needs to be that space for people to consider their options, you’re never going to get the definitive answer.

**Amanda: An important message there. We talk a lot about using digital tools to be able to do things better at scale, better ways to give information, but I think what you’re saying is we can’t replace certain elements of human connection, we can’t underestimate the value of that. You made a really good point earlier as well about how so many of these decisions have uncertainty and it can be really difficult to navigate the complexities of a health system. Perhaps even more challenging if you have struggles with health literacy or if you are an underserved group in some way or another.**

**Kelly, I think you mentioned that some of your research has also touched on developing information for underserved groups. Can you tell us a bit more about that?**

Kelly: We recognised that there are many underserved groups that are not represented in research, in literature, and applied for additional funding to do some specific targeted projects in the community. There were a couple of examples I can mention. One was inspired by colleagues at the Royal Marsden who made some videos about prostate screening and the had black men and their family members talking about this in a relaxed barber’s shop setting. Through reaching out into the community I was connected with Lee Townsend from Macmillan who’s been making these barbershop videos around London for the last seven years. He’s focussed on a number of topics like mental health, vaccination and cancer. We connected and it was really about making that connection in the community, him as a trusted leader, and having formed partnerships with some of the barbers who opened up their barbershops for filming these sessions and went way beyond that.

One of them has actually trained as a counsellor himself because he said men are coming for a haircut and actually they have a bald head, they don’t need the haircut, they’re coming actually for the chat. Because it’s benefitting their mental health and they felt able to open up about topics that they wouldn’t talk about even at home with their family members or with their friends, such as symptoms of cancer, going for cancer screening or presenting for treatment if they were symptomatic. It’s really powerful. We’ve actually filmed six videos with black and minority ethnicity patients, talking about their cancer experience and they’ve really both helped others by setting an example that it’s okay to talk about these things. Also, through the process an added benefit was helping themselves, so it was peer support. When they came to the barbershop to film their stories, they didn’t need to stay for the whole time but they did stay for the three hours. They said afterwards how helpful it was just to hear others in a similar situation sharing their stories. One of them told me he’s got up on stage and shared his cancer journey and he’s been going to these patient groups and talking when he didn’t feel able to do that in the past. It’s been a great project and we’re going to be adding the videos to the CanGene-CanVar patient decision aid website soon.

Another thing that we’ve done in the diet and lifestyle section of the website where it talks about things that people might do to lower their chances of getting cancer have partnered with Professor Ranjit Manchanda who had some colleagues in India and made some infographics that specifically depict patients of a South Asian heritage and the types of foods that they might be choosing to give examples of how they might for example try to get more fibre in their diet to lower the chances of getting bowel cancer or trying to eat more fruits and vegetables or drink less alcohol. It shows images of Indian patients. What people have told me in my research, my interviews, focus groups, is they tend to go and try to search for something that means something to them, so they’re looking for someone like me. One of the patients I filmed she said that she had breast cancer as a young black woman and she was only middle-aged women on the websites. She thought why is this, do black women not get breast cancer or young women like me? For her to share her story was very brave but also has the potential to help a lot of other people in the community.

**Amanda: That’s really powerful, so understanding those nuances in different cultures or communities or groups is just so crucial to really being able to also develop information or messages or provide care that’s going to really reach those people where they are, I guess.**

**This has been a really fantastic conversation. If we could end with a final question, it would be great to hear from your perspective just one thing that you’d like to see in the next five to ten years when it comes to care for inherited cancer susceptibility conditions. Helen, let’s start with you?**

Helen: I think that in developing the guidelines one of the things that we’ve had to struggle or grapple with is a lack of evidence and the lack of the data that’s available for some of these conditions. I’m really hoping that over the next five to ten years that we will see much more data on cancer risks and outcomes of surveillance progress for people who have an inherited predisposition. Then we can utilise that information to be able to share with patients to enable them to make best decisions about their care. There’s a number of initiatives that are currently underway thinking about how we might better collect data on patients with inherited cancer predisposition in the UK, through registries, so I am really hoping that we manage to get some useful data that we can then use in our discussions with patients going forward.

**Amanda: Thank you. Kelly?**

Kelly: I think that over the next five to ten years as awareness and availability of genetic testing continues to increase, we know that there will be more and more families identified who have a higher genetic risk of getting certain cancers. We can’t replace that personalised counselling that takes place, face-to-face or sometimes telephone and video appointments with a healthcare profession. So there are more resources needed for the NHS to deliver this. To compliment that, the patient website decision aid that we have co-designed is one way to help. What patients tell us they would like, access to a central trusted source of information that’s up to date. Importantly in genetics it’s very fastmoving, there’s a lot of research, guidelines are changing, and it’s very crucial to have information that’s correct and relevant for people, and also meaningful. We can only do that by partnering together with patients and co-designing things rather than designing them and asking them afterwards if they’re useful. It’s a partnership all the way through that we all benefit from.

As I said earlier, it’s not a one-size-fits-all, decision-making is so personal and shared decision-making is recommended but we don’t always have enough time in clinic to really address all of the issues that the patient might not have even thought about themselves. Having something like a patient-facing resource website booklet that they can look at in their own time, prepare for their questions that they really want to focus on in clinic, it might help give them the confidence to bring something up that they might not have otherwise. It’s about a number of different ways of helping to support people. We’ve identified that there are gaps in care that we could try to help address if we have more resource in future. Those are my aspirations. Thank you, Amanda.

**Amanda: Thank you. And Rochelle, to you?**

Rochelle: I think for me I would like to have as many people as possible to understand or know about their genetic mutation status. We know people don’t even know about the fact that they may have a genetic mutation that may make them more susceptible to cancers, and we know that even then if you do can you get access to testing to know whether you’ve got it or not. That is the most important thing. My mum, if she’d known that some of this was related, if she’d had that awareness that breast and ovarian cancer in your family was related to potential genetic risk, maybe she would have pushed harder to get testing and maybe she wouldn’t have been tested when it’s too late. In the end, all this knowledge and empowering people with knowledge, whether that be about empowering people with the knowledge that they may have a genetic mutation, there’s a possibility of the genetic mutation, that these things are related and empowering people through the knowledge of knowing their genetic mutation status, all that is something that saves lives. From my view, it undoubtedly probably has saved my life and so my hope for the future is that we can empower more people like me and we can save more lives.

**Amanda: Thank you for our guests today Dr Helen Hansen, Rochelle Gold and Kelly Kohut. If you enjoyed today’s episode, we’d love your support. Please subscribe to The G Word on your favourite podcast app and like, share and rate us wherever you listen. I’ve been your host, Amanda Pichini. This podcast was edited by Mark Kendrick at Ventoux Digital and produced by Naimah Callachand. Thanks for listening.**