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Title: The Role of the Breast Care Nurse in patient and family care

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Aims and objectives

This study aims to describe the role of the Breast Care Nurse in caring for patients and families.

Background

The Breast Care Nurse is an expert clinical nurse who plays a significant role in the care of women/men and their families with breast cancer. The role of these nurses has expanded since the 1990s in Australia.

Design

Descriptive study

Methods

An online survey was sent to Breast Care Nurses using peak body databases (n=100). The survey consisted of nineteen nurse roles and functions from a previous Delphi technique study. Nurses rated the importance and frequency of role elements using a five point Likert scale and four open-ended questions relating to role.

Results
There were 89 respondents. Most of the sample were from remote (n=37, 41%) and rural areas (n=47, 52%). The majority of responses regarding importance and frequency of the BCN role had a mean score above 4, which corresponds to ‘moderately important’ and ‘occasionally as needed’. There were significant differences between the level of importance and frequency on 10 items. Four role themes arose from the thematic analysis: Breast Care Nurses as patient advocates; patient educators; care coordinators and clinical experts.

Conclusions
This study delineated the important nurses role in caring for patients and families during a critical time of their life. Further, it details the important nursing roles and functions undertaken by these nurses and compared this to the frequency with which these nurses perform these aspects of their role.

Relevance to clinical practice
This study further delineates the important role that the nurses play in caring for patients and families during a critical time of their life. It extends further the frequency and importance of the supportive care and the need to educate their nurses on their role in providing spiritual care and research.

'What does this paper contribute to the wider global clinical community?'

- This study has further delineated the important role that the Breast Care Nurses play in caring for patients and families during a critical time of their life.
- The study has detailed the important nursing roles and functions undertaken by Breast Care Nurses and compared to the perceived importance to the frequency with which the Breast Care Nurses perform these aspects of their role.
- Breast Care Nurses roles and functions are essential elements in providing enhanced patient and family centred care.
- Need to encourage these nurses to research their practice and provide spiritual care to patients and families.
INTRODUCTION

Breast cancer is currently the third most commonly diagnosed cancer in Australia. In response to the prevalence of breast cancer in Australia, the role of Breast Care Nurse (BCN) was established in the early 1990s (Ahern et al. 2015; White & Wilkes 1999). BCN work at the level of advanced practice nurses and are classified as either Clinical Nurse specialists or Clinical Nurse Consultants depending on what State or Territory in Australia they work in. However the five (5) domains they work in are: clinical service and management planning; clinical services planning and consultancy; clinical leadership; research; and education (Wilkes, Luck & O’Baugh, 2015). The Australian Institute of Health and Welfare (2014) estimates there will be 15,740 new cases of Breast Cancer in Australia in 2015, which equates to 12.4% of all new cases of cancer. In 2015, the projected number of deaths from Breast cancer is 3,065; 25 men and 3,040 women (Australian Institute of Health and Welfare 2014). While it is difficult to estimate the number of BCNs working in both the public and private health sectors, there is considerable investment in funded BCNs positions, particularly through the McGrath Foundation. In 2014, there were 100 McGrath funded BCNs across Australia (McGrath Foundation 2015). This paper revisits the role of BCNs from the perspective of the nurses themselves.

BACKGROUND

BCNs are an essential support for patients and their families during the cancer experience (Paynter et al. 2013). Working closely with patients and their families, they provide direct physical and emotional care. Various authors have reported the support needs of the patients and their family during the breast cancer experience (Cheng, Sit, Chan, So, Choi and Cheng, 2013; McGrath, Patterson, Yates, Treloar, Oldenburg and Loos, 1999; Minstrell, Winzenberg, Rankin, Hughes and Walker, 2007). These needs include dealing with fatigue, fear of cancer spreading or returning, the opportunity to talk to someone, information about treatment and prognosis including the benefits and side-effect of the treatment, and information about support groups. Eley & Rogers-Clark (2012)
found patients reported a difference in their care depending on whether they had the support of a BCN or not. Specifically, they reported that a BCN improved the quality of direct patient care, continuity of care and the patients’ perception of their care. Additionally, patients’ reported care was improved when the BCNs coordinated their care, including organising support and referral (Griffiths et al. 2013; Paynter et al. 2013).

BCNs provide a continuum of care supporting patients and families from diagnosis to completion of their treatment or palliation and this requires multiple specialist skills. Consequently, the definition of the role of the BCN is broad and the nuances of the roles and functions are frequently explored (Amir et al. 2004; Paynter et al. 2013; Yates et al. 2007). Watts et al. (2011) suggest the role includes providing information and emotional support, patient advocacy and liaising with the multidisciplinary team. In a small two-part study, Jones et al (2010) interviewed 18 nurses in Queensland, Australia and developed six themes from the data and then developed a 59-item survey which they presented to 21 BCNs and 21 other nurses and doctors. They explored the scope of the role and found direct patient care, coordinating patient care, attending multidisciplinary team meetings, educating other health professionals and administration were the major roles of these nurses. They added the critical aspect of the BCN role was provision of information and support not only to patients and families but also to health professionals in the form of education.

Further, BCNs provide practical advice to patients and their families (Eicher et al. 2012; Halkett et al. 2006). BCNs work with patients and their families at diagnosis, during surgery, radiotherapy, chemotherapy, rehabilitation and palliation (Eicher et al. 2012; Eley & Rogers-Clark 2012) individually and as part of a multidisciplinary team (Reed et al. 2010; Yates et al. 2007). Eicher et al. (2012) adds that BCNs have increased responsibility for diagnostic procedures and seroma management. Notably, BCNs apply their specialist nursing skills across a range of settings and work with patients and their families over a number of months or years. Yates et al. (2007) developed clinical competencies for BCNs and outlined five domains, including supportive care, collaborative
care, coordinated care, information provision and education, and clinical leadership. This aligns with the Australian Specialist breast nurse competency standards (National Breast Cancer Centre 2005).

While there is existing work that describes the role of the BCNs in Australia, there is a need to determine the importance BCNs place on their roles and functions (Ahern & Gardner 2013; Ahern et al. 2015; Jones et al. 2010).

Ahern and Gardner (2013) conducted a literature review of patient perception of the BCN role and models of care and reported three findings. First, despite BCNs working in their specialty for over 20 years, women still have unmet needs. Second, the role is unregulated and the different geographical settings they work in determine their roles and expectations. Third, there is insufficient level one or two evidence regarding the role of BCN in Australia. They recommended that a more specific definition of the roles and functions of the BCN needs to be established. In a complimentary study, Ahern, Gardiner and Courtney (2015) surveyed 50 BCNs regarding the provision of support and informational care and related this to the Australian Specialist BCN Competency Standards (National Breast Cancer Centre 2005). Specifically, they sought to explore role differences of BCN related to their geographical location. They found differences in providing care between geographical areas, but all the BCNs felt they met the competency standards. The study reported here expands the current knowledge by examining particular roles and functions of BCN in relation to providing patient and family care.

Aim

The aim of the study is to describe the role of the BCNs in Australia and their provision of patient and family care to determine the perceived importance of specific nursing roles and functions and compare this to how frequently the BCNs performed these aspects of their role. The focus of this study was to determine the BCNs’ views regarding how much importance they placed on particular aspects of their roles and compare this with how frequently they thought they undertook these activities.

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METHODS

Design

The research design was a descriptive survey with both quantitative and qualitative questions. This approach was appropriate because survey research can describe attitudes and opinions of a sample of the broader population of interest (Keough & Tanabe 2011). The questions were informed by the roles previously identified by (White & Wilkes 1999) in a Delphi study.

Data collection

BCNs were invited to complete the survey. A purposive sample of BCN were invited to participate in the survey. A Qualtrics link to the survey was provided on the McGrath Foundation website (Qualtrics 2013) and there were some participants who were informed by unanticipated snowball.

There were three sections in the survey. The quantitative component consisted of two sections, each having 19 closed ended questions pertaining to the BCN role. Section one (1) asked participants to rate the importance they placed on each of the 19 nursing activities measured on a Likert scale of 1 – 5 where 1 indicated “not important” and 5 “very important”. Section two (2) asked how frequently they had performed these activities in the last year and 1 indicated “never, not part of my role” and 5 indicated “extremely frequently” (see Table 1). The third (3) section had four open ended questions (see Table 2). These questions sought to understand the perceived differences between the rural/remote and urban BCN roles and functions and to capture other nursing activities or opinions they considered important that were not covered in the survey questions. Demographic information was also collected (see Table 3).

Data analysis

Statistical analysis was undertaken using SPSS version 22 (IBM Corp 2013). Descriptive and non-parametric statistical analysis was performed. Demographic information was collated descriptively. Quantitative data were analysed using Wilcoxon Rank Sum test and mean values of the scores for

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“importance” and “frequency” for each item were identified and compared (see table 2). Qualitative findings were analysed manually. Qualitative data were read and re-read by two members of the research team to identify similarities and differences in the data and this continued until consensus was reached. Data were coded and categorised to develop themes. This ensured dependability and credibility of the resultant themes (Thomas & Magilvy 2011).

Ethics

Ethics approval was obtained from the relevant University Human Ethics Committee. The participant information sheet was provided on the entry point to the Qualtrics website (Qualtrics 2013). Completion of the online survey was considered implied voluntary informed consent and using the online survey to collect data ensured participant anonymity.

Participants

There were 89 respondents in total including 73 Australians, a 73% response rate from the McGrath Foundation, and 16 non-Australians. The majority of these nurses were working in rural (n=37, 42%) and remote (n=47, 53%) areas and 5, (5%) worked in urban areas. The highest level of qualification was PhD (n=3, 3%), 14 (16%) of the participants held a Master degree and 15 (17%) a Bachelor degree. The majority of nurses (n= 37, 53%) held Graduate Certificate and Graduate Diploma qualifications (see table 1). The 16 non-Australian participants were included in analysis as there were no statistically significant differences in the findings when they were included in data analysis.

The mean age of these nurses was 50 years and the age range was 29-67 years. The average number of years working as a nurse was 28 years, with an average 6 years as a BCN.
RESULTS

Quantitative findings

The majority of responses regarding importance and frequency of the descriptors of the BCN role had a mean score above 4, which corresponds to ‘moderately important’ and ‘occasionally as needed’. There were three items measuring frequency that fell below this ranking, items 6 (\( \bar{x} = 3.81 \)), 12 (\( \bar{x} = 3.81 \)) and 19 (\( \bar{x} = 3.91 \)), however, they were ranked as ‘moderately important’. Two items (1 and 3) were ranked higher for frequency than importance, but they were not statistically significant (see Table 2).

Examining the Wilcoxon scores (see Table 2), there were statistically significant differences between the level of importance and frequency on 10 items.

Qualitative findings

The open ended questions elicited a picture of the scope and breadth of the BCN clinical care roles and responsibilities.

Four themes emerged from the BCN participants regarding roles they saw as important to their position. The themes were: being a clinical expert; being a care coordinator; being a patient educator; and being a patient advocate.

Being a clinical expert
The scope of the nursing care activities, including advocacy, education and treatment coordination, exemplifies the complexity of the BCN role. The clinical skills of these BCNs were apparent when these nurses outlined some of the clinical interventions they undertook, including wound dressing, seroma aspirations, drain removal, providing bioimpedence measurements of arms, and chemotherapy. Caring for the patients and their families also included providing counselling when needed. There were differences in the specific clinical skills demanded of the BCNs depending on where they worked and the model of service provision and/or model of care. Many of these BCNs worked in rural and remote areas where there was an expectation that they were skilled in all aspects of patient care and their BC pathway/trajectory from diagnosis to survivorship or palliation. In particular, the rural nurses commented that they found themselves “often working as sole practitioner” where they needed to be multi-skilled. One nurse noted that “often the role demands activities which push professional boundaries and can be limited due to scope of practice”. Ensuring their skills and knowledge were up-to-date was seen as important for their capacity to support patients. Being a clinical expert also encompassed their commitment to their professional development and that of their peers. This was expressed by comments such as “mentoring other BCNs” and providing “peer support to fellow BCNs, this is very fragmented in Australia”.

Being a care coordinator

These BCNs developed long term relationships with the patients, their family and friends, often supporting them during their acute phase of diagnosis and treatment through to providing palliative care. The need to be a care coordinator was explicitly stated by these nurses and they saw themselves as the “pivotal contact point during the continuum of care”. As previously stated, the breadth of the care they coordinated was extensive and their coordination role included activities such as diagnostic procedures, surgery, medical and radio oncology appointments, liaising with general practitioners, psychological services, dieticians and social workers. Coordinating care also helped the BCNs to “keep up to date with what is happening to my patients”. The onus to resolve
health care issues for patients was also seen as an important part of the role as a care coordinator, and as one nurse stated, they “have to sort out more problems”. To effectively coordinate care and resolve problems, relationships and networking with the staff in the referral services was seen as essential, in particular for the BCNs working in rural areas, as one nurse stated “hugely important is relationship building with other disciplines ... taking the time to build and maintain these working relationships is often under-rated/ reported”.

**Being a patient Educator**

These BCNs reported that education was needed for patients, their families, community groups and organisations. Education was seen as an integral part of their role. Their role as educators encompassed their clinical skills and professional experience as they were often the only consistent resource for these patients and their families. These nurses were able to help patients and their families understand the complexities of the medical and surgical interventions. One nurse wrote “I am able to sit down with patients and explain their path (pathology) reports”. In addition to their role as an educator, the breadth of situations where they engaged in providing education included presenting to breast cancer patient groups, cancer volunteers, hospital staff, local high schools, women in the community as well as undertaking breast cancer promotion.

**Being a patient advocate**

These BCNs described their role as advocates and saw this role as an important part of their work supporting patients and their families. Many of these nurses reported that advocating for patients was needed within the health care sector and as part of their role within the broader community. The BCNs commented on the need within the health care sector for the BCNs to understand the complexities of health care services, have knowledge about what is available to patients and importantly to ensure these resources are accessible. The BCNs reported the necessity to ensure “patients are scheduled appropriately” and the need to be “working with surgical team to ensure...”
surgery is done within specified time frames”. Accessibility of services was of particular importance for those nurses working in remote/rural areas. These nurses stated that advocacy was needed because they were “working in areas with limited services and specialists and not everything at your fingers” and there was often “a lack of resources”. Therefore, how to access expertise from the city and how to ensure patients can travel for treatment was of high concern. Additionally, there was acknowledgment of the personal hardship, distress and social and financial costs of women needing to travel and organise accommodation when seeking services outside their home town. One BCN wrote “these families face mums being away from drought stricken property where they are shooting livestock daily and the psychological impact on the women”.

Much of the public advocacy was undertaken through BCNs organisations or when they act as a community educator. This was also seen as a leadership role for these nurses. Some nurses were members of working groups looking at models of care and quality improvement and said that “this ensures a voice in how service provision is shaped for breast cancer clients” and that they could improve patient care by influencing national and international policies.

**DISCUSSION**

The quantitative findings suggest there are many areas where the BCNs reported a significant difference between the frequency and importance of their roles and function. It is of note, however, that most of the mean scores were above 4.50. This indicates that these roles were both important and frequently enacted by 90% of the BCNs. Further, there were a number of areas where the frequency with which the BCNs can undertake nursing activities meets the nurses’ specified level of importance. The nursing care areas with the greatest match between importance and frequency are those that involve providing patient centred care, such as advice, psychosocial support, counselling and support to women at all phases of the women’s breast cancer journey. This included caring for the women in the hospital and community. These findings align with, and extend, previous research.
on a smaller sample (Jones et al., 2010; Watts et al., 2011). Our findings extends the work of Jones et al. (2010) by providing data from a larger sample of BCNs. Similar to Jones et al. (2010), this study shows that these BCNs see information sharing and psychological support as both important and frequently undertaken functions of their roles. While Jones et al. (2010) suggested day to day frequency of activities related to support, it is difficult to delineate or compare the importance and frequency of particular activities in the information provided in their article.

Both the quantitative and qualitative findings from this study reflect the importance of the BCN role as an educator, care coordinator and clinical expert. The educator role is broad-ranging and covers educating patients and their families through to members of the community. The education items included item 3 and 17 and the perceived importance and frequency of these roles were not significantly different. Items 1, 2, 14, 16 and 18 referred to the BCN role as an expert and again the perceived importance and frequency were not statistically different. Similarly, item 15 exemplifies the importance given to being a care co-ordinator. This noticeable match between the quantitative and qualitative highlights some of the roles these BCNs ranked as both important and frequently enacted. Further, these findings align with the Australian Specialist BCN Competency Standards, specifically supportive care, coordinated care and information provision and education (National Breast Cancer Centre 2005).

The quantitative findings highlight the areas of care where there is a discrepancy between the perceived importance of the activity and the frequency with which it is enacted are those that are, arguably, domains that are often reported as being underutilised. This is reflected in the questions regarding public advocacy, research and spirituality where mean frequency is below 4.0. They ranked being a public advocate low in frequency in the quantitative data but advocacy was a theme in the qualitative data. The advocacy they described in the qualitative data, however, pertained to being a patient advocate. Patient advocacy, therefore, can be seen as an important part of their role and this has previously been reported in the literature (Admi et al. 2011; Jones et al. 2010). Akin to public advocacy, research and support of spiritual needs were both ranked low for frequency. The
lower score for the “role of researcher” aligns with the literature, such as the work by Wilkes et al (2015) who found only 43.7% of specialist nurses thought research should be a frequent part of their role. This is not to suggest these nurses are not informing their practice with best evidence, rather this was not a frequently enacted part of their role. In the qualitative data, it is important to note that inherent in the “being a clinical expert” theme, these nurses acknowledged their commitment to professional development and mentorship. The third role nurses engaged in less frequently was supporting the spiritual needs of the patient and their families. This aligns with the work of Balboni et al. (2014) who found that nurses provided spiritual care less often than they would like. As suggested by McSherry & Jamieson (2011), it could be that nurses need more guidance to help support them to provide spiritual care.

**Limitations**

As with all on-line surveys, a limitation was the number of respondents. However, 73 participants represented 73% of the BCNs from the McGrath Foundation. While in 2014 there were 100 McGrath Foundation BCNs (McGrath Foundation 2014), it became apparent from the data that other BCNs accessed the survey. Additionally, the data collection tool was a retrospective self-report questionnaire and therefore relied on participants accurately remembering past events. This can impact on the veracity of the data. While Ahern et al. (2015) found a difference between regional and urban BCNs, in our study we only had five BCNs from urban areas, but this may be because there are more McGrath Foundation nurses in non-urban health regions.

**CONCLUSIONS**

This study further delineated the important role the BCNs play in caring for patients and families during a critical time of their life. Further, it detailed the important nursing roles and functions undertaken by the BCN and compared this to the frequency with which the BCN performs these aspects of their role.
RELEVANCE TO CLINICAL PRACTICE

The findings align with other studies since 2001 but reinforces their roles as educators, care coordinator and clinical expert. It extends further the frequency and importance of the supportive care they provided. It also highlights the need to educate these nurses on their role in providing spiritual care and undertaking research. This could be achieved by providing links to specialist BCN websites and organisations which could be the most appropriate way to provide education as these BCN usually work in isolation, particularly the McGrath BCN who were the major part of the sample.

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DOI: 10.1046/j.1440-1584.1999.00216.x

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Table 1. BCNs' highest qualification

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Rural</th>
<th>Urban</th>
<th>Remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Diploma</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bachelor degree</td>
<td>2</td>
<td>0</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Graduate Certificate</td>
<td>16</td>
<td>3</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>Graduate Diploma</td>
<td>7</td>
<td>2</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Master degree</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>PhD</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>7</td>
<td>45</td>
<td>89</td>
</tr>
</tbody>
</table>
Table 2. BCN Roles and Functions in patient and family care – Importance and frequency *p<0.05

<table>
<thead>
<tr>
<th>Item</th>
<th>Descriptor of BCNs Roles and Functions</th>
<th>$\bar{x}$</th>
<th>$\bar{x}$ frequency</th>
<th>Wilcoxon 2 tailed $p$ value</th>
<th>Wilcoxon Z score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>A triage manager in assessing patient’s educational needs and social needs and appropriately referring to the proper source for help</td>
<td>4.27</td>
<td>4.38</td>
<td>0.324</td>
<td>-0.986</td>
</tr>
<tr>
<td>2.</td>
<td>A nurse who is seen by patients as a person who can advise on appropriate action to be taken when problems arise</td>
<td>4.83</td>
<td>4.7</td>
<td>0.09</td>
<td>-1.694</td>
</tr>
<tr>
<td>3.</td>
<td>A caregiver and overseer of the educational needs of the patients with breast cancer</td>
<td>4.52</td>
<td>4.57</td>
<td>0.576</td>
<td>-0.559</td>
</tr>
<tr>
<td>4.</td>
<td>A specialized nurse who provides and facilitates educational, practical and psychological support for patients and their families experiencing breast cancer diagnosis and treatments</td>
<td>4.96</td>
<td>4.72</td>
<td>0.002*</td>
<td>-3.111</td>
</tr>
<tr>
<td>5.</td>
<td>A supporter of the breast cancer patient in understanding the strong emotions that accompany a breast cancer diagnosis</td>
<td>4.84</td>
<td>4.67</td>
<td>0.033*</td>
<td>-2.130</td>
</tr>
<tr>
<td>6.</td>
<td>A supporter of the spiritual needs of the patient and family</td>
<td>4.35</td>
<td>3.81</td>
<td>0.000*</td>
<td>-4.820</td>
</tr>
<tr>
<td>7.</td>
<td>A nurse who gives advice to women with breast cancer and their families</td>
<td>4.74</td>
<td>4.7</td>
<td>0.599</td>
<td>-0.526</td>
</tr>
<tr>
<td>8.</td>
<td>A member of a multi-disciplinary team who provides treatment for women with breast disease</td>
<td>4.75</td>
<td>4.46</td>
<td>0.01*</td>
<td>-2.585</td>
</tr>
<tr>
<td>9.</td>
<td>A nurse who is a resource person for women with breast disease in hospital</td>
<td>4.78</td>
<td>4.52</td>
<td>0.022*</td>
<td>-2.288</td>
</tr>
<tr>
<td>10.</td>
<td>A specialist able to educate, care for and psychologically support family and patients with genetic concerns, lymphoedema, reconstruction queries or problems, body image and clinical trials</td>
<td>4.72</td>
<td>4.42</td>
<td>0.011*</td>
<td>-2.537</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Mean 1</td>
<td>Mean 2</td>
<td>df</td>
<td>t</td>
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<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>11.</td>
<td>A nurse who counsels the family of a woman with breast cancer</td>
<td>4.37</td>
<td>4.13</td>
<td>0.037*</td>
<td>-2.085</td>
</tr>
<tr>
<td>12.</td>
<td>A public advocate for the needs of breast cancer patients and their families</td>
<td>4.31</td>
<td>3.81</td>
<td>0.000*</td>
<td>-3.866</td>
</tr>
<tr>
<td>13.</td>
<td>A nurse who provides a liaison role between health-care professionals to facilitate co-ordinated,</td>
<td>4.84</td>
<td>4.57</td>
<td>0.002*</td>
<td>-3.095</td>
</tr>
<tr>
<td></td>
<td>integrated care of the women with breast cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>A nurse who provides psychosocial support to women with breast cancer throughout all phases of the</td>
<td>4.73</td>
<td>4.62</td>
<td>0.269</td>
<td>-1.105</td>
</tr>
<tr>
<td></td>
<td>breast cancer journey</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>A nurse who is a resource person in the hospital and the community</td>
<td>4.56</td>
<td>4.35</td>
<td>0.066</td>
<td>-1.836</td>
</tr>
<tr>
<td>16.</td>
<td>A nurse who counsels women with breast cancer</td>
<td>4.49</td>
<td>4.47</td>
<td>1.00</td>
<td>0.000</td>
</tr>
<tr>
<td>17.</td>
<td>A provider of educational material for the patient and the family to answer questions and address</td>
<td>4.78</td>
<td>4.79</td>
<td>0.934</td>
<td>-0.082</td>
</tr>
<tr>
<td></td>
<td>their fears during the breast cancer experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>A nurse who gives advice to families of women with breast cancer</td>
<td>4.58</td>
<td>4.47</td>
<td>0.277</td>
<td>-1.086</td>
</tr>
<tr>
<td>19.</td>
<td>A researcher for your facility, keeping the latest information on changes in breast cancer care and</td>
<td>4.29</td>
<td>3.91</td>
<td>0.006*</td>
<td>-2.724</td>
</tr>
<tr>
<td></td>
<td>educational information available for doctors, nurses, other health workers and patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3. Qualitative questions BCN

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
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<tbody>
<tr>
<td>1</td>
<td>If you work in a rural/remote area, how do you think your role differs from a nurse working in the city area?</td>
</tr>
<tr>
<td>2</td>
<td>If you work in a city area, how do you think your role differs from a nurse working in a rural/remote area?</td>
</tr>
<tr>
<td>3</td>
<td>Are there any additional roles that are important to your position? (Please list below)</td>
</tr>
<tr>
<td>4</td>
<td>Any other comments.</td>
</tr>
</tbody>
</table>