

Information needs of nurses regarding breast disease

By Margaret I. Fitch, Pamela Chart and Natalie Parry

Abstract

The purpose of this study was to identify the information needs of nurses regarding benign breast conditions and breast cancer. One hundred and five Ontario nurses who are directly involved in providing information to women were interviewed. The majority of nurses indicated feeling either somewhat or very comfortable during their discussions with women and perceived their knowledge was sufficient for answering women's questions. Nurses rated existing information concerning discovery of breast abnormalities and the diagnostic phases the highest in terms of quality, quantity and accessibility. Overall, a large proportion of nurses did not perceive gaps in information for nurses about breast disease. This work raises interesting practice questions for nursing in light of the reports by patients that they experience difficulties obtaining information.

During the past several years, the topic of women's informational needs about breast cancer has been receiving significant attention. In 1992, the House of Commons standing committee report entitled "Breast Cancer: Unanswered Questions", contained poignant testimony regarding difficulties women encountered trying to access information about breast cancer treatments. In 1993, the National Forum on Breast Cancer heard results of a national survey of breast cancer survivors in which the primary need of women, who were newly diagnosed with breast cancer, was for more information at the time of diagnosis and the opportunity to speak with other women who had breast cancer. In the words of the survivors:

Cancer services and information are definitely lacking in my area. There seems to be no one who can answer my questions regarding my situation, and I am sure I am not an unusual case... I rarely come away from the doctor's office or clinic feeling any more informed than when I went in. (The National Forum on Breast Cancer: Survey of Breast Cancer Survivors: Comments and Suggestions, November, 1993, p.14)

Survivors and newly diagnosed women need to be constantly updated and informed. Too many women slip through the proverbial cracks in the system and have absolutely no idea of the help that's out there and available to us. (The National Forum on Breast Cancer: Survey of Breast Cancer Survivors: Comments and Suggestions, November, 1993, p.10)

I found gathering, researching information on my cancer and options, in order to be sure I could give informed consent, an anxiety-provoking and stressful chore - and I am surrounded by helpful, knowledgeable people and trained in research. It

must be immeasurably more terrifying for a woman without these resources. (The National Forum on Breast Cancer: Survey of Breast Cancer Survivors: Comments and Suggestions, November, 1993, p.20.)

The impact of breast cancer upon a woman and her family and friends can be profound, creating a myriad of issues (Cook, 1984; Northouse & Swain, 1987; Kameny, Wellisch & Schain, 1988). Many women have questions they want answered but say they do not know where to get the information they need (Cawley, Kostic & Cappello, 1990; Houts, Ruesenas, Simmonds, Hufford, 1991). Much of the information which exists is not written in understandable language nor is it sensitive to issues of ethnicity, culture, age or socio-economic status (Cancer 2000, 1991). The messages women receive about the disease and its treatment can be confusing or even conflicting (Northouse, 1989; Wingate & Lackey, 1989). Similar criticisms have been offered regarding information about the prevention of breast cancer, screening, palliative care and long-term survivorship.

To make informed decisions about breast cancer, women, their families, friends and health care providers need access to the right information, in a helpful format, at the time it is needed. Canadian women, as well as their families, are becoming more outspoken about the inadequacies surrounding the availability and access to breast cancer information. Their efforts have influenced increased emphasis on information provision.

To respond to the inadequacies surrounding access to information, five regional breast cancer information exchange projects were created. These five projects are funded by Health Canada for the ultimate purpose of assisting persons living with breast cancer and their families, caregivers and those at risk for developing cancer in making informed decisions about a variety of concerns relating to breast cancer. The specific objectives in Ontario were to facilitate access to state-of-the-art information and serve as a catalyst for cooperative activity regarding the exchange of information about breast cancer.

The Ontario Breast Cancer Information Exchange Project (OBCIEP) selected the issue of informational needs of health care

ABRÉGÉ

BESOINS INFORMATIONNELS DES INFIRMIÈRES EN MATIÈRE D'AFFECTIONS DU SEIN

Cette étude avait pour but d'identifier les besoins informationnels des infirmières relatifs aux affections bénignes du sein et au cancer du sein. On a réalisé des entrevues auprès de cent cinq infirmières de l'Ontario qui fournissent des informations directement aux patientes. La majorité des infirmières indiquaient qu'elles se sentaient assez à l'aise ou très à l'aise lors de leurs discussions avec ces femmes et qu'elles considéraient leurs connaissances comme étant suffisantes pour répondre à leurs questions. Les infirmières ont accordé les plus hautes valeurs de qualité, de quantité et d'accessibilité aux informations existantes se rapportant à la découverte d'anomalies du sein et aux phases du diagnostic. Dans l'ensemble, une grande partie des infirmières ne percevaient aucune lacune dans l'information conçue à l'intention des infirmières sur les affections du sein. Cette étude soulève des questions intéressantes pour les soins infirmiers puisque les patientes signalent qu'elles ont de la difficulté à obtenir une telle information.

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professionals as one focus for study. Health care professionals are a primary source of information for patients about breast cancer. Additionally, professionals require up-to-date information about breast cancer and breast cancer resources if they are to make the correct decisions about treatment and care and share information with patients.

The OBCIEP considered it was important to assess the need for information about breast cancer within the groups of health care professionals who are in most direct contact with women. Family physicians, surgeons and nurses were identified for the purposes of the project. This article presents the results of a survey of nurses in the province of Ontario regarding their informational needs about breast cancer and benign breast disease.

Methods

The study utilized a cross-sectional survey design to examine the issue of information needs regarding breast disease from the perspective of nurses who are directly involved in providing information to women. Telephone interviews were conducted with 105 nurses who currently practice in the province of Ontario. Only those nurses directly involved in discussing breast cancer and related issues with women three or more times in an average month were invited to participate. Each nurse only answered questions pertaining to the topic areas appropriate for her practice.

Participants

Nursing practice is so diverse, nurses may be interacting with women and talking about breast disease in a wide range of settings. Given this diversity, sample quotas were established at the onset of the study to ensure participation from nurses in relevant hospital settings (including nurses from outpatient, ambulatory care, surgical day care settings as well as inpatient surgical and medical settings) and community settings (including nurses from public health, home care nurses, nurse examiners in the Ontario Breast Screening Program, nurses in general practitioners' offices, hospice/palliative care nurses and community health centre nurses). Quotas were also established to ensure geographical diversity. With the exception of the nurses working in general practitioners' offices, the sample was selected randomly from lists of contact names provided to the OBCIEP from the respective organizations (i.e., Ontario Breast Screening Program, community hospices, regional cancer centres, hospitals with oncology units, etc.) The samples for nurses working in general practitioners' offices and public health nurses were obtained from an electronic version of the Canadian Medical Directory.

Data collection procedures

All interviews were conducted using a computer-assisted telephone interviewing (CATI) system, through Insight Canada Research's tele-research centre located in Toronto. With this system, phone numbers and other relevant data of the target audience are

downloaded to the CATI system and prospective participants are dialled randomly by modem.

When the call was answered, the interviewer discussed the study with the nurse and determined if that nurse met the eligibility criteria of direct involvement in providing information to women about breast disease (i.e., discuss breast disease three or more times in an average month with women in the course of daily practice). If the eligibility criterion was met, the nurse was invited to participate in the study. Consent to participate was elicited during the call and arrangements were made for the actual interview.

During the interview session, the interviewer read the survey questions directly from a computer screen and entered the responses into the computer database. Thirty per cent of the interviews were directly monitored during the actual interview to check for accuracy.

Interview schedule

The interview schedule was designed for the purposes of this study. Clinical experts, researchers and breast cancer survivors assisted in the survey development, reviewing drafts of the instrument as it evolved.

Three broad topic areas provided the structure for the interview questions:

- benign breast conditions and the screening and prevention of breast cancer;
- the discovery of breast abnormalities and the work-up or diagnostic phase (including surgery); and
- the post-surgical treatment of breast cancer, rehabilitation and living with breast cancer, and non-curative breast cancer.

For each topic area, questions were posed concerning the frequency of the nurse's involvement in talking about the topic area, the types of information that were discussed with women, the nurse's perception of her own comfort and knowledge in talking about the topic area, the information available regarding the topic area, sources of information for nurses, and adequacy of information in the topic area for both nurses and patients. Ordinal scales were used to assess knowledge (sufficient, somewhat sufficient, somewhat insufficient, insufficient) and comfort (very comfortable, somewhat comfortable, somewhat uncomfortable, very uncomfortable) in responding to women's questions. Availability, quality and quantity of information was assessed with a 10-point rating scale (1 meant very poor and 10 meant excellent).

Data analysis

The data analysis was descriptive. The frequency of responses for each of the survey questions was calculated. In each of the broad topic areas, the analysis included only those nurses who indicated they were directly involved in the provision of information concerning that topic within their daily practice at least three times a month. Mean scores were calculated for the items with scaled responses (i.e., availability and adequacy of information/tools). The results are accurate to (plus or minus) 10%, 19 times out of 20.

Results

Sample

A total of 246 telephone calls were placed for the purposes of the study. Eighty-six (35%) were busy, not answered or had a telephone answering machine. Eight (3.2%) were incorrect numbers. Forty-two (17%) nurses who were contacted were ineligible because they were not directly involved in the provision of breast disease information to women. Of the 110 who were eligible nurses (44.7% of the calls), 105 (94.6%) completed the interview.

The distribution of the settings in which the participants work is depicted in Table One. Forty-nine per cent (n=51) of the sample work in hospital settings while 51% (n=54) work in community settings. In terms of the regional distribution, 12% (n=13) are from Metro Toronto/Metropolitan Belt, 22% (n=23) are from

Table One: Distribution of nurse sample (n=105)

	Setting type	Per cent of nurses in sample
Hospital	Outpatient - Ambulatory care	15%
	Inpatient - Day care/surgery	17%
	Inpatient - Medical	16%
Community	Public health	9%
	Visiting nurse	10%
	Nurse examiner with OBSP	5%
	Nurse in GP's office	16%
	Hospital/palliative care	6%
Community health centre	6%	

southwestern Ontario, 24% (n=25) are from eastern Ontario, 25% (n=26) are from central Ontario and 17% (n=18) are from northern Ontario.

Frequency of involvement in discussing breast disease

In an average month, 57% (n=60) of the nurses in the sample routinely (more than five times) discuss breast cancer and related issues with their patients. The remainder of the nurses in the sample (43%) occasionally discuss breast cancer and related issues with women (three to five times).

Nurses in the sample reported their direct involvement in information provision did not necessarily include all three broad topic areas covered in the survey questions. Fifty-six per cent (n=59) of the 105 nurses who participated in the survey indicated they are directly involved in the topics of benign breast conditions and the screening and prevention of breast cancer; 36% (n=38) are directly involved in the topics of discovery of breast abnormalities and the work-up or diagnostic phase (including surgery); and 66% (n=69) are involved directly in the topics of post-surgical treatment of breast cancer, rehabilitation and living with breast cancer, and non-curative breast cancer.

Level of comfort and sufficiency of knowledge

Overall, among the nurses who are directly involved in the provision of information to women in each of the three broad topic areas, the majority of the nurses (73% - 91%) indicated feeling either somewhat or very comfortable during their discussions with women (see Table Two). The highest proportion of nurses who indicated feeling very comfortable (59%) are directly involved with the topics of benign breast conditions. The lowest proportion who indicated feeling very comfortable (28%) are involved in the topic area of non-curative breast cancer.

Table Three also presents the extent to which nurses perceive their knowledge to be sufficient to engage in discussions with women. Overall, among the nurses who are directly involved in providing information to women concerning each of the broad topic areas, the majority of nurses (74% - 92%) believe that their knowledge is either completely or somewhat sufficient to have their discussions with women. The highest proportion of nurses who indicated their knowledge was completely sufficient (36%) was observed for those working with the topic area of benign breast conditions. The lowest proportions of those who believe their knowledge is completely sufficient were observed for those working with the topic areas of post-surgical treatment of breast cancer (5%) and rehabilitation and living with breast cancer (7%).

Types of information discussed

For each of the broad topic areas, nurses were asked what types of information are discussed most frequently. Table Four highlights these findings. The type of information discussed most frequently varies across the phases of the illness trajectory. For example, learning how to perform a proper breast self-examination is a frequently discussed topic in the screening phase, while treatment options emerge as a frequently discussed topic during the diagnostic and treatment phases. Emotional and coping issues become more predominant during the later phases of illness.

Sources of information used by nurses

Nurses were asked which sources of information they had used in the past six months for the purposes of their own learning about breast disease. Across all topic areas, nurses had turned most frequently to medical journals and hospital and other libraries (see Table Five). The Canadian Cancer Society was used for all topic areas by 18% to 23% of the nurses. Physicians and specialists were cited by 21% of the nurses as an information source in the diagnostic phase.

Table Two: Nurses' perception of comfort level in discussing breast disease

Topic	Number of nurses*	Percentage of Nurses			
		Very comfortable	Somewhat comfortable	Somewhat uncomfortable	Very uncomfortable
Benign breast conditions	59	59	32	8	
Discovery of breast abnormalities and diagnostic phase (including surgery)	38	39	45	13	
Post-surgical treatment of breast cancer	69	42	45	10	3
Rehabilitation and living with breast cancer	69	31	58	12	
Non-curative breast cancer	69	28	45	20	5

* Nurses responding for each topic area are directly involved in discussing the topic with women three or more times a month.

Table Three: Nurses' perception of knowledge sufficiency to discuss breast disease

Topic	Number of nurses	Percentage of nurses		
		Very sufficient	Somewhat sufficient	Somewhat insufficient
Benign breast conditions	59	36	56	7
Discovery of an abnormality/diagnostic phase (including surgery)	38	24	63	13
Post-surgical treatment of breast cancer	69	5	71	24
Rehabilitation and living with cancer	69	7	78	15
Non-curative breast cancer	69	13	66	21

Rating of information for nurses and perceived gaps

Table Six presents the mean scores for nurses' ratings of the quality, quantity and accessibility of information available to increase their own knowledge about breast disease. Information concerning the discovery of breast abnormalities and the diagnostic phases received the highest mean rating for quality (X=6.97), quantity (X=6.39) and accessibility (X=6.51). Information concerning non-curative breast cancer disease received the lowest mean rating across all three dimensions (quality, X=5.89; quantity, X=5.82; accessibility, X=5.74).

In response to a question about gaps in information, a large proportion of the nurses did not perceive gaps in information for nurses regarding breast disease, or to a lesser degree, do not know what the gaps are. Forty-nine per cent of the nurses involved in discussions about benign breast conditions, 68% of those involved in

discussions about discovery of abnormalities and the diagnostic phase, and 70% of those involved in discussions about rehabilitation, living with cancer and non-curative disease indicated no gaps in information for nurses. Fifteen per cent, 13% and 16% respectively did not know if there are gaps. The specific gaps mentioned included materials on benign breast conditions (19%), communication between patients and doctors (3%), guidelines (3%), addresses for information (3%), and types of disease conditions (3%).

Perspectives on patient education for breast disease

Nurses also shared their perspectives on educational materials for patients. For those sharing information regarding benign breast conditions and screening, 64% (n=38) reported using patient educational tools. The most frequently reported tools were booklets and brochures (87%), videos (28%) and breast models (20%). This group rated the accessibility of patient information as higher than

Table Four: Types of information about breast disease discussed most frequently with women by nurses

Topic areas	Number of nurses	Type of information discussed most frequently (mentioned by >10% of respondents)
Benign breast conditions	59	How to do proper self examination (42%) Best follow-up schedule (14%) Treatment of fibrocystic breast disease (12%)
Screening and prevention of breast cancer	59	Screening guidelines (66%) How to do proper BSE (51%) Benefits of early detection (15%)
Discovery of breast abnormalities and the diagnostic phase (including surgery)	38	Treatment options (39%) Information about expected outcome (32%) Procedures involved in pre-diagnostic work-up (32%) Process, if malignancy (16%) External support resources (11%) Sources of information (11%)
Post-surgical treatment	69	Treatment (62%) Emotional support/coping issues (41%)
Rehabilitation and living with cancer	69	Emotional support/coping issues (48%) Prosthesis (19%) Side effects (17%)
Non-curative breast cancer	69	Emotional support coping issues (57%) Symptom management (13%)

Table Five: Sources of information used in past six months for nurses' own learning about breast disease

Sources of information	Benign conditions and screening n=59	Discovery of abnormalities and the diagnostic phase (including surgery) n=38	Post-surgical treatment; rehabilitation, living with cancer, noncurative disease n=69
Medical journals	44%	39%	38%
Hospital/other library	24%	29%	36%
Canadian Cancer Society	20%	18%	23%
Textbooks	12%	-	-
Physicians/specialists	7%	21%	10%
Literature reviews	8%	16%	12%
Women's magazines	8%	11%	7%
Conferences/seminars	2%	8%	14%
Nowhere/did not look	10%	3%	9%

either its quality or quantity (see Table Seven). Nearly half (49%) of the nurses stated there are no gaps in patient information about benign breast conditions and screening, while 19% do not know if there are gaps. The specific gaps that were identified included articles on benign breast conditions (5%), hand-outs (3%), and information in other languages (2%).

For those nurses involved in sharing information about discovery of abnormalities and the diagnostic phase (including surgery), 83% (n=32) make use of educational tools. The items mentioned most frequently included booklets and brochures (91%) and breast models (22%). Specific mention of using the Canadian Cancer Society brochures was made by 39% of these participants. Nurses rated the quality of this patient information higher than the quantity or accessibility (see Table Seven). Over half (53%) of these nurses do not perceive gaps in patient information about breast abnormalities and the diagnostic phase, while 18% do not know if there are gaps. The areas where nurses do perceive there are gaps included simple, clearly-written information (8%), information on procedures of the pre-diagnostic work-up (5%), sources of information about breast cancer overall and treatment options (3%) and where to go after finding a lump (3%).

For those nurses sharing information about post-surgical treatment, rehabilitation, living with cancer or non-curative disease, 38% (n=26) made use of educational materials. Booklets and brochures were mentioned most frequently. Seventy per cent mentioned using Canadian Cancer Society brochures, 26% mentioned manufacturers' materials and 19% use other brochures. The quality of these materials was rated higher than either the quantity or accessibility (see Table Seven). The majority (59%) of these nurses believe there are no gaps in patient information in this area, while 19% are not aware of any gaps. The specific gaps which are perceived include the availability of information in doctors' offices (4%), information on treatment choices (3%), coping or dealing with breast cancer (3%) and coping with side effects (3%).

Referrals to support groups and information lines

The majority of nurses who discuss issues relating to post-surgical treatment of breast cancer, rehabilitation, survivorship and non-curative breast cancer usually speak to women about support groups (80%). A further 13% sometimes or infrequently speak about support groups, while a minority (7%) never do so.

The majority of nurses believe that they have an adequate amount of information on support and/or advocacy groups (77%), while 19% do not. An additional three per cent do not have an adequate amount of information, but do not want it.

Nine in ten (92%) of the nurses in this group believe that support groups are very helpful (75%) or somewhat helpful (17%). Furthermore, 22% of the nurses who are directly involved in relaying information or support to patients regarding the post-surgical treatment of breast cancer, rehabilitation, survivorship or non-curative breast cancer also play an active role in local support groups.

Overall, 63% of the nurses are aware of the Cancer Information Service (CIS). Among those nurses who are aware of the CIS, 26% either always (14%) or usually (12%) refer their patients to it, while 33% sometimes do so, 18% rarely do so, and 21% never do so.

Discussion

This study was undertaken to identify informational needs of nurses about breast disease. The data offer interesting perspectives regarding nurses' knowledge for practice, particularly in the areas of information provision and patient support. However, care must be taken interpreting the results because of the small overall sample (N=105) and subgroup sizes. The work ought to be conceptualized as a pilot study, raising questions and providing the basis for future work in a larger population.

Nurses work in many different settings and fulfill a variety of roles. Despite carrying similar role titles, the expectations for roles may vary, not only as a function of the individual practitioner but also as a function of institutional policy. Hence, the opportunity to interact with patients will differ across settings as will the expected performance level regarding information provision. These

Table Six: Nurses' rating of available information about breast disease

Topic area	Number of nurses	Mean scores* (range)		
		Quality	Quantity	Accessibility
Benign breast conditions	59	6.21 (2-10)	5.98 (2-10)	6.39 (1-10)
Discovery of abnormalities and diagnostic phase	38	6.97 (2-10)	6.39 (2-10)	6.51 (2-10)
Post-surgical treatment of breast cancer	69	6.70 (2-10)	6.31 (2-10)	6.16 (1-10)
Rehabilitation/living with breast cancer	69	6.57 (3-10)	6.36 (2-10)	6.31 (2-10)
Non-curative breast cancer	69	5.89 (2-9)	5.82 (1-10)	5.74 (1-10)

* Scale: 1 = very poor/10 = excellent

Table Seven: Nurses' rating of available patient-oriented information about breast disease

Topic area	Number of nurses rating	Mean scores* (range)		
		Quality	Quantity	Accessibility
Benign breast conditions	59	5.19 (1-9)	4.89 (1-9)	5.33 (1-10)
Discovery of breast abnormalities and diagnostic phase	38	5.44 (1-9)	5.28 (1-9)	5.00 (1-9)
Post-surgical living with cancer non-curative	69	6.18 (1-10)	6.00 (1-10)	6.05 (1-10)

*Scale: 1 = very poor/10 = excellent

observations create a challenge in defining appropriate sampling frames for a study such as the one reported here and in interpreting the data.

The sample in this work offers a cross-section of nurses in inpatient and outpatient settings. There was a high participation rate from those who were contacted. However, specific role expectations regarding information provision were not explored with the participants. The sample consisted of nurses who are currently involved in information provision about breast cancer in their current practice. In that regard, then one would expect these nurses to be familiar with the knowledge about breast disease and the patient educational tools available.

The nurses in this sample perceive that the quality, quantity and accessibility of information for themselves and for women is far from ideal. In terms of the information which nurses require to increase their own knowledge, information on non-curative breast cancer, followed by benign breast conditions requires the most improvement in its quality, quantity and accessibility. With regard to patient-oriented information, however, nurses perceive that the quality, quantity and accessibility of information on benign breast conditions is the poorest of the three general areas. These results are similar to those from the physicians and surgeons surveyed earlier (OBCIEP, 1994 & 1995). Nurses indicate that the area of benign breast conditions is an important element of their practice and that more information is required on benign breast conditions for themselves and for women. Based on these results, the Ontario Breast Cancer Information Exchange Project has initiated the development of informational tools for health care professionals and for women on benign breast conditions.

The data reveal that nurses are very frequently involved in helping women find ways to cope with breast cancer and its implications as well as providing them with support. The extent to which the nurses

reported they are comfortable answering questions and perceive their knowledge to be sufficient enough to do so, was surprising. The low level of comfort and sufficiency of knowledge observed raises concerns, particularly with a sample of practitioners who are routinely engaged in sharing this information. The extent to which they are very comfortable is lower for issues related to the discovery of breast abnormalities and the diagnostic phase, and particularly rehabilitation, living with cancer and non-curative breast cancer, in comparison to the other issues. Less than 15% of nurses believe their knowledge about the post-surgical treatment of breast cancer, rehabilitation and living with cancer or non-curative cancer is completely sufficient. It is unclear from this work, however, how much of the discomfort stems from actual lack of professional knowledge and how much stems from the challenge of answering questions regarding emotionally charged topics. Furthermore, any lack of professional knowledge could be a function of the individual not possessing the information or the information not yet being available. There are many questions in the arena of coping and adaptation with life-threatening illness which still require research.

The list of information topics discussed most frequently with women raises questions about the nature of those conversations and who establishes the agenda for the interaction. During the telephone survey, nurses were free to respond to this question by mentioning more than one topic area. However, the frequencies with which the topics were reported imply that some nurses and women do not engage in dialogue about many topic areas. It is not clear from this work which topics women initiate and which topics nurses initiate, but the data raise questions about the standards of practice regarding information provision. Do nurses have a standard set of topic areas which are presented to each patient together with an offer of the opportunity to talk about those areas? Do nurses share information primarily in response to the questions women pose? Do women talk

with nurses about topic areas only when they are unable to obtain the information from other sources?

Based on the types of issues raised by survivors regarding access to information, there is ample evidence to help nurses devise a standard list of topic areas regarding breast disease for discussion with women. These topic areas could be presented and the opportunity offered to talk about them. Nurses have a unique opportunity to support women and facilitate access to information. To be successful in this endeavour, nurses must be sensitive to the full range of topics women might wish to discuss and be knowledgeable about the resources available to assist women. Sharing information about services with patients allows them to choose the type of service they wish to use.

Nurses in this study had high regard for support groups and many usually refer women to them. However, 20% of nurses do not usually discuss support groups with women. It is not clear whether these nurses live in areas where there are no support groups available or the lack of discussion is an individual practice pattern. Recent work regarding the value of self-help groups, especially for women with breast cancer, emphasizes the important role such groups can play for women (Phillips, et al., 1996). Given the role nurses have in the promotion of coping and adaptation, it is important that all nurses include information about available peer support in their conversations with women. For those women who live in areas where a support group does not exist, long distance telephone support programs are available (CCS, 1996).

The high proportion of nurses who reported no perceived gaps in information either for themselves or for women was surprising in light of women's reported difficulties in accessing information and nurses' reported level of knowledge regarding breast cancer. These observations could imply that information is available and the problems may lie with accessing it. The barriers to access may exist on various levels.

For nurses, there is a professional responsibility to pursue the knowledge required for practice through the various continuing development avenues. Perceived levels of discomfort in performing some aspect of practice ought to be a trigger to pursue additional learning. Currently, pursuit of continued learning can be a challenge for nurses given the heavy clinical workloads many nurses carry. Being self-directed and making use of self-learning methods is critical for nurses in the future. The development of self-learning packages for nurses could be a useful endeavour.

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The barriers patients experience accessing information could be resolved to some extent if health care professionals, and in particular nurses, were aware of the available information resources and routinely discussed these resources with patients. The challenge, however, is often one of finding out what resources exist. Resources may be designed by an individual agency and not widely disseminated. Easily accessible databases regarding information resources are needed for clinical practitioners as well as readily available patient information tools. Within clinical settings, user-friendly mechanisms need to be developed for sharing information about resources with patients. As professional practitioners, nurses may need to take the opportunity to gather together their own resource kit (i.e., reliable, valid materials to use for sharing information with patients) rather than wait for an institution to design its own.

In conclusion, nurses need to develop a standard of practice whereby they routinely ask patients if they have any questions or want certain types of information. Individuals will want different amounts of information at different points in time. Providing the opportunity for patients to review what they are learning and whether new questions have arisen is also important. Learning and coping are ongoing processes requiring ongoing dialogue. As an individual moves through the experience of living with cancer, new questions will arise and the need for information will continue to unfold. Nurses have a unique and important role to be responsive to these changes and facilitate access to information and support. ♡

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