Searching for a professional identity: a qualitative study of the oncology nurses role in a multidisciplinary breast-unit team

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Abstract. *Background and aims* Interprofessional collaboration concept in healthcare implies and evoke enhanced nurses' involvement and role consideration. However, these aspects are often taken for granted by professionals and organizations, while there is not always a mutual awareness of them in interprofessional relationships. Our research aimed to investigate: 1) the impact of nursing within a multidisciplinary team of breast-unit practice; 2) healthcare team and patients' perceptions of the interprofessional care pathway dimensions (e.g. decision-making process participation, model of care adopted and patients' centrality). *Methods*. A qualitative exploratory approach was adopted. Researchers were involved in the activities of the Breast Unit (B.U.): department meetings, review of unit guidelines, observation of professional practice and documents. Moreover, in -depth interviews with 14 patients and a 15 healthcare professionals from the B.U. were conducted. Qualitative content analysis was the approach chosen to infer data from interviews' transcripts. *Results.* The analysis' critical themes showed a very marginal nursing presence and the unfulfilled role of the Case Manager, especially in organizing the patient's journey and facilitating team communication. Additionally, lack of shared decision-making, team communication problems, and limited interprofessional collaboration could constitute signs of mono-professional B.U. management and potential devaluation of the role of oncology specialist nurses in managing patient care. *Conclusion*. The supportive roles of cancer nurse and case manager are still struggling within cancer care pathways and the multidisciplinary team, albeit healthcare organizations have been trying to implement and integrate these roles into cancer care programs for several years in Italy. However, our study suggests that the implementation of interprofessional collaboration and a person-centered model of care can also occur through socio-cultural awareness and identification of the role of the specialist nurse.

Keywords: case manager; specialist nurse role; clinical decision-making; person-centred care; interprofessional care; qualitative study; content analysis.

Introduction

The process of interprofessional collaboration engages nurses and other healthcare professionals in sharing knowledge, goals and responsibility to build and support an inclusive and holistic model of care. It also encourages the team members to increase a shared decision-making process, improving members' role appreciation and job satisfaction (1, 2, 3). Although interprofessional approach premises focus on the patient's

centrality (4, 5), modern healthcare facilities seem to be still linked to a model of care based on a procedure-centred and disease-centred approach (6). Moreover, literature states that a shared person-centred care approach increases interprofessional collaboration (3, 6, 7).

Breast Units play an important role in oncology care, providing a pathway of excellence for the diagnosis, treatment, and follow-up of breast cancer patients (8, 9, 10). The Breast Unit should gather professionals and specialists involved in breast cancer care and organized in a multidisciplinary team. This team is coordinated by a clinical leader and is composed of oncologists, surgeons, radiologists, pathologists, radiotherapists, psychologists, oncology specialist nurses, radiology technicians and data managers.

Nurses should occupy a privileged position within of the interprofessional team in virtue of their specific pivotal role in promoting a shared decision-making model and translating the medical language for patients and caregivers (11, 12).

Therefore, oncology nursing is concerned with understanding patients' illness experience with a holistic model of care, thus supporting the shift from the biomedical paradigm of curing into a person-centred caring approach (9, 12, 13, 14). However, little attention has been given to patient centredness effects on nursing role (15), particularly in relation to interprofessional care and collaboration (16)

Case Manager of a Breast Unit is advanced clinical nursing role in complex health care pathways (16, 17). This role implies possessing in-depth knowledge in oncology care, supporting patients and their families during the cancer pathway and it is recognized as the first contact for the patient and caregivers (11, 17). The Case Manager's role of coordinating the care pathway is intertwined with the interprofessional collaboration (18), which has , shown little implementation in Italian healthcare settings (19, 20).

Aims

Our study aimed to explore the nursing role in an Italian Breast Unit, guided by the following questions:

- What is the level of interprofessional collaboration perceived by the Breast Unit team?

(This question can help to highlight if the nursing role is included within interprofessional collaborative perspective).

- What are nurses and case managers' role self-perception?

(This question can provide a better understanding of nursing identity concerning its role in the interprofessional team).

- What are patients and professionals' perceptions of nursing and case managers' roles?

(This question is essential to understand if any sociocultural misunderstandings and stigmatisations influenced the nursing role degree of involvement within the breast unit team).

Method

Design

A qualitative exploratory research design was adopted to gain an in-depth understanding of professionals and patients' perception on nursing role. During a period of 6 months, the researchers were involved in a number of activities for data collection: participating in meetings and visiting the units, analysis of documents and guidelines, direct observation of collegial meetings and patients' follow-up visits, and conducting in-depth interviews with patients, medical and healthcare professionals.

Data Collection

This study was conducted in a recent implemented Breast Unit located in Central Italy. A conveni-

ence sampling approach was adopted to recruit study participants. The participants were healthcare professionals and patients. Medical and health care professionals composing the interprofessional team were recruited through a ward meeting and with the support of the clinical coordinator, who acted as a researcher-interviewee communication facilitator. The researchers aimed to interview all professionals involved in the weekly ward meeting, and to include at least one representative for each professional profile within the Breast Unit.

Patients were recruited and contacted with the support of an association for breast cancer patients. The association agreed to contact all the eligible members via email and/or during meetings explaining the nature of the research project and giving further information to who showed interest to participate. Inclusion criteria for patients consisted in having accomplished their clinical pathway and being at the follow-up stage. Demographic questions were kept to a minimum to protect the privacy of participants due to the personal nature of the questioning (21).

Interviews were conducted and digitally recorded during January-June 2018; a member of the research team transcribed each interview verbatim after they were completed.

Two different sets of interviews were designed for patients (Table1) and Professionals (Table 2). The open-ended questions gave interviewers the possibility to explore the topic in-depth or to ask additional questions when needed. Interviews questions for patients' (table 1) were directed to elicit their experience with the Breast Unit services, team members and their in-

Table 1. Patients' Interview Questions

1	When and how did you find out about this Breast Unit?
2	Before being admitted to this unit, did you have the opportunity to choose, to seek for treatment elsewhere, or to attend different hospitals/ward? Which factors influenced your choice?
3	How did the first contact with the structure come about (with which subjects and offices you have been in contact at the beginning)?
4	What kind of information did you receive at the beginning? How and by whom were they communicated.
5	With which professionals did you come into contact during your experience in this Unit? What kind of relationship did you establish with them?
6	What kind of therapeutic pathway did you follow (structures / professionals you encountered, for how long, etc.)?
7	Have you and / or family members been involved in choosing your care pathway? In addition, How?
8	What difficulties have you encountered so far on your journey? How did you try to overcome them and who helped you in this?
9	Based on your experience, would you consider other professionals in this pathway in addition to those with whom you came into contact?
10	Which organizational and / or relational aspects could be improved in this pathway and how?
11	Based on your knowledge of other health facilities, what do you think about the type of healthcare assistance received in the care path offered by the Breast Unit?

Table 2. Healthcare Professionals' interview questions

1	Can you tell me about your training, career path and your main work experience? What are the areas and problems you dealt with in your clinical practice?
2	Based on your experience and knowledge of the healthcare world, what do you think are the main critical points and the main excellences of the Italian healthcare organization?
3	How long have you been employed in your current role, in this structure and what kind of clinical situations you have been involved, so far? What kind of relationship do you have with the other departments/structures and with the staff?
4	What critical issues and/or excellences do you think emerge in managing this health facility? Moreover, from whom and from what do you think they depend?
5	In your opinion, what are the main innovations (in the broad sense) that have been carried out in recent years in the structure in which you work?
6	Who started/suggested/designed this innovation (State, Region, Directorate-General, doctors, nurses, etc.)?
7	What kind of changes to the structure or organization of work were needed to be able to start and implement it? Moreover, Which professionals and external institutional actors (oncological networks, associations, general practitioners, etc.) have been specifically involved and how?
8	How did the various structures and personnel involved react to innovation (actively, passively, hostile, etc.)? What kind of problems have emerged and how have we tried to address them?
9	What kind of effect did it have on the patient and / or caregiver?

volvement within the caring process and therapeutic choices.

The interview questions posed to professionals were focused on interprofessional collaboration, role expectations, approach to patients and perceived innovation in the Breast Unit organization.

Data analysis

Qualitative content analysis was adopted to infer data from the textual material, to produce knowledge, insights, representations and descriptions of practices and actions (22, 23). Researchers conducted inductive qualitative data analysis and then verified for findings using software Nvivo plus 12. Throughout the content analysis process, authors aimed to search for latent contents within data. In order to do this, firstly authors independently read all textual material several times and agreed to define and choose appropriate meaning units (words and small phrases related to the topic meanings).

Secondly, they searched for statements that had similar meaning through content and context, condensing those into initial categories (24). Subsequently, authors identified main themes containing selected categories, through a process of abstraction, constant comparison and interpretation (25, 26).

In order to guarantee research rigour, authors organized regular inter-analysis meetings to share findings and to exclude non-fitting categories (23). Research validity was supported by actualizing an ordered and traceable series of cognitive acts, like the process leading to theme creation (22). In addition, transferability was ensured by describing the research context, participants' characteristics and selection, the data collection process and analysis. Some study findings overlapped with previous studies, thus providing research confirmability (26) while credibility was reached by considering both patients' and professionals' perceptions of the topic. Lastly, Nvivo software was used to ensure consistency in the selection of categories or the creation of new ones.

Ethical Considerations

This study obtained formal authorization from the Head Office of the Italian Region involved and by the Ethical Committee of the Hospital, as required by Italian law. Study participants were verbally informed of the research objectives and formally agreed to be interviewed; they all signed a consent form. All information and data collected were treated anonymously and confidentially.

Results

The Breast Unit interdisciplinary team members (N= 15) who agreed to participate were representative of all the professions involved in the unit activities. Therefore, the group of professionals interviewed was composed by Nurse Ward Coordinator, (2) Oncology Nurses, (2) Radiologist, Radiotherapy Nurse, Radiotherapist, Consultant Oncologist, (2) Physiatrist, Pathologist, (2) Psychologists, Surgeon, Physiotherapist. The patients who agreed to participate were all women (N= 14) recruited by the association for breast cancer patients. Themes that emerged are synthesized in professionals (Visions of Nursing Role, A question of medical language and a supportive figure) and patients (The care pathway, Cure without Care).

Professionals' perception

Visions of Nursing Role

The impact of oncology nursing practice is acknowledged within the Breast Unit professional team. However, the non-inclusion of nurses in weekly multidisciplinary meetings (MDM) is an impeding factor

in their involvement. Although, nurses' participation in the patient's decision-making is described as very important, there are no traces of this process in professionals' narratives.

"…greater importance is given to pure clinic tasks therefore nurses primarily assist patients, they go to the meetings only if they have time. I think this is the reason... if on one hand, their contribution (to MDM*) is important, on the other they can stay here only for eight hours shift…*" Psychologist-1

Nurses' word frequency to describe their routines and working-life highlighted a strong sense of the tasks and the procedures that might shape nurses' perception of their practice. On the other hand, when most learning processes happens in the workplace and mostly task-oriented, nurses may be less likely encouraged to participate in clinical reasoning processes, to contribute to decision making and reflect the caring relationship with patients. In this way, nurses' acceptance of this task-orientated role could influenced the underestimation of the relational role as an effective nursing competence. In addition to this, the medical profession's vision of nursing within the MDM also seemed a very practical one, depicted as if it were an admin position (like "fixing appointments") or highlighting just the bureaucratic tasks of nursing.

"When they arrive, we take them in, so let's get the patient in and show her the bed where she goes. We ask for the name and surname, the data, we do the nursing folder ... we do ..." Nurse 1

"For a nurse who has contact even during education therapy, information and patient management, knowing these things certainly has an added value. But he is there listening, then he has the role of fixing the appointment when it is needed" Radiologist

The use of the terms such as "the sick" or "the ill" when referring to a patient or a person was found frequently within textual material. This use of colloquial terms carries the risk of continuing to put at the centre of nursing care a pathology rather than the person and their lived experience.

"…We are also sharing a path with them to optimize patient management…I deal only with the management of the sick who undergo surgery here in R. E. and that's it" Nurse Coordinator

Nurses working in the Breast Unit oncology surgical ward have an educational role consisting of teaching women (or caregivers) about post-surgery movement limitations, possible housework and mastectomy surgical drainage management at home. Although this role has been implemented, it seemed to still be described as an undervalued or a taken-for-granted role. In other words, an educational role as part of a routine of soft skills and not yet officially documented. Conversely, nurses working in radiotherapy described their educational role as documented and recognized. In fact, this formally charted nursing intervention seemed conducive to establish a better relationship with the patients.

"We do health education for the sick, but also to their caregiver. Home care nursing for the first time in supervision goes every day, or every two days or when it is necessary to replace drainage, at the patient's home to support the caregiver…" Nurse Coordinator

*"I mean, when a patient wants to talk and tells us something, let's try to be useful ... Then, of course, I take care of giving hygiene advice, health education. For example, relating to personal hygiene, the use of cream, deodorant, exposure to the sun, etc. "*Radiotherapy Nurse

Despite nurses' physical closeness to patients, their supportive role is described as limited to a few occasions of listening and offering some supportive words. In fact, nurses' supportive role is not highlighted in the professional team interviews. Furthermore, it is described as more or less a series of very cautious acts (a "being supportive but not going into details") paying attention to avoid entering the domain of the psychologist or another professional. Nevertheless,

nurses' (and physiotherapists') perception of being less entitled to offer emotional support did not discourage them from bridging trust and referring patients to the psychologist's support if needed.

"…the patient vents a little bit. We had patients who started crying … in short …We listen. We cannot give Great advice, but we listen and try to reassure her" Radiotherapy Nurse

"…and therefore, probably to have meetings to be helped but also to help the patient. So, we don't mention obvious things and not being trivial…" Nurse 2

A question of medical language

Communication issues and medical language are also at the centre of a number of reflections in professionals' interviews. Participation in the collegial meeting can be challenging for non-medical staff because of the excess of medical language and terms linked to a pathology. It is therefore necessary to learn the language and culture to be able to interact or to understand the presented cases. The decision-making process is generally medically led and nurses do not usually participate due to ward excessive workload (case managers were supposed to take part but they do not yet participate). Moreover, when asked if they would like to participate in this meeting, there was a feeling of uneasiness among nurses because it was perceived as a moment of medical information and so "they can't see the use they can make out of it".

"We need to have information, but only our strict competence. It is obvious that we do not want to know about life, death and miracles of surgery. Let's say some more information wouldn't be bad" Radiotherapy Nurse

"…there are no nurses. If we were to succeed, here is the improvement we need to make, to welcome this type of professional should inevitably review the language" Psychologist 2

Some professionals perceived little space within MDM for discussion about patients' life or sharing other points of view. In fact, these meetings are concerned with pathological aspects of care and are mono-professionally managed. During MDM, each case is assigned and discussed by the specialist based on the respective medical treatment chosen; therefore, it seemed that the discussion followed a sort of professional hierarchy.

"…many of us are spectators, some professionals are spectators. Those who immediately make the decision… are: pathologist, based on what he has seen, radiologist who says about the images and oncologist share the oncological path…" Physiatrist1

Patient-professional communication was perceived as too fast, not at the right time and/or that the information was not fully understood. Moreover, healthcare professionals' proximity seemed to be a key factor to help translate to patients the medical language. In fact, the relationship was described as more intimate and conducive to communication in those Breast Unit contexts where patients stayed longer or have the chance to meet the same staff several times (such as chemo- or radiotherapy units).

"So many things are said, they (Patients) have heard, but not everything is understood or metabolized (at least we have had this impression). Because we know the things that are being said during medical visits and when we present these to them again, we see the surprise, the amazement, they widen their eyes" Radiotherapist

A supportive figure

Healthcare professionals expressed the need for a figure, a professional role, which should act as a support throughout the patient pathway. Perceptions were different about this issue, going from someone who should act with special empathy, to suggestions of someone "who keeps track of the operative part".

"The patient should always relate with a person, a professional figure. The patient, when she talks to a doctor, and to that doctor, to that nurse, feels empathy, harmony". Radiologist

Perceptions of the Case Manager role within this Breast Unit were controversial: it seemed like a hidden role (it is shared by two part-time nurses), most of the professionals affirmed that they knew about its existence, but they did not know if it was an active role. There were, like for nurses' role, opposite visions among professional team' interviews about the case manager, on one hand a perception of an administrative role (e.g. keeping file documentation, making sure patients have an appointment in time) and on the other a role of high oncology nursing expertise.

"There is the figure of the Case Manager…they say they are not, but for me they are. That is, they are nurses who take care of coordination, they show us, patients, before surgery." Surgeon

Medical professionals' representations of the Case Manager role were of a procedural/task orientated one. Doctors highlighted more the Case Managers' bureaucratic work rather than caring for the patient relationship. Nurse coordinator perceptions of this role seemed wider, depicting more role interactional power, encouraging their participation in the MDM. Furthermore; the coordinator described them fundamental for the patient support program.

"…it would be appropriate to have a Case Manager. The one who keeps the ranks of what is the operative part: the patient has to take the exams or has to do the X-ray or has to redo an MRI or a Breast-Scan..." Oncologist.

"They are the ones who follow the preoperative path, they follow the whole path…there is a series of continuous information, which let me know where my patient is on the path…I gradually know the step ..." Nurse Coordinator

"...there is a need for a Case Manager that: is holding the ranks, following the patient on his path, making sure that everything is done and that the patient arrive at his or her destination. The patient made that request, so this means that each of us need to take notes, make notes, etc., to remember to make that call, to make that request ..." Pathologist

Nurses, physiotherapists and radiotherapists are generally more aware of the impact of psychological support for patients and staff. Nurses' reflections highlighted how psychological support is often crucial for patients and that it is an important aid. Nevertheless, it was interesting to note that only nurses adopted a self-reflective attitude regarding their work and patients.

"…if it should happen to me, the world would collapse on me, I would think ..., I would try to be positive but if I had help ...I would be calmer". Nurse 1

Patients' perception

The care pathway

This theme collects the categories about patients' perceptions of their pathway from admission to discharge. This theme showed aspects of the pathway reflecting a model of care that is more procedure- or disease-centred with a general lack of nurses' involvement. In addition, patients' interviews showed that their perceived supportive figure was a medical professional; for example, some patients referred to doctors for issues normally nursing-related competence.

"…the welcoming oncologist prepared me, communicated, described…organised the whole process, from the reception, pre-examination tests, up to the intervention…" Patient.7

The contrast between care pathway protocols and the needs of the person, as well as an expression of a practical but not shared solution, finds an emblematic representation in the description of surgeon and oncologist different problem-solving style. In this case, the oncologist's order to purchase only a specific type of bra proves unsuitable for the patient's breast, whereas the surgeon came later suggesting an adaptable and economic solution for her.

"... I think both looked at the whole situation, but surely one looked more at me, the other looked more at the protocols" Patient.1

In patients' interviews recurred the colloquial expression "they do it all", meant to provide a short definition of how the Breast Unit and the relative pathway worked. This "they do it all" can reflect the vision of a clinical pathway as a predictable and reassuring protocol. On the other hand, it showed patients' ambiguity between gratitude for taking charge of everything but at the same time a lack of participation in the decision-making process.

"So, I simply did what they told me without asking myself too many questions. I didn't ask myself: why am I here "Patient.8

"I don't mean to be involved…it wouldn't make sense. But maybe to have a moment when doctors invite you, they explain what they decided to do, explaining the pros and cons"- Patient.2bis

The aspect of how patients were received into the Breast Unit was described with various experiences of abandonment or discontinuity of care, especially in the follow-up phase. In fact, once patients left the ward or concluded the protocol, some experiences of abandonment or lack of references and support emerged. For example, during the frequent planned follow-up visits, it often happened that patients were examined by a different oncologists and patients perceived negatively this.

"…I missed this a little… this is a bit of a missing link in my chain. I always get visited by different doctors. Do you know what I mean? Every time I make a check-up, there is always a different doctor ..." Patient. 2

Although the nursing role was marginal and practically inexistent in patients' interviews, on a few occasions the nurse was perceived as the translator of medical language and as having a non-specified supporting role throughout the pathway.

"When I was with the doctors it seemed easy, but there were certain things that we asked nurses because the contact with them is much more frequent. Maybe if you are there doing the therapy, you can think of something then ask it to the nurse, because the nurse is already there ..." Patient. 7

Cure without Care

Dialogues concerned mostly with therapy permeated the patient-professional relational space; thus depicting a context where the word cure is more frequently used than the word care. On the other hand, they refer to potential curing even when professionals were performing a caring act.

"Because I was pregnant and I was catapulted there, so I leaned more towards B. (Oncologist) That is, it seemed to me that he was the one who immediately had me cured" Patient. 2

Several interview extracts merged into a category regarding perceptions of the lack of a professional reference role/figure who accompanies, follows and takes care of the whole caring pathway. It was interesting to highlight those aspects of follow-up care, expressed by some patients as "no one cares for you anymore".

"After the surgical ward, when you enter there (oncology) there is a great ... there is an absolute sense of abandonment. Nobody cares about you anymore. It's all a problem to find them (oncologists); they are extremely busy, eh? "Patient.3bis

The "reference person" described by patients was mostly an ideal professional figure providing information, continuity of care and presence. From some patients' perceptions, it seemed that the oncologist embodied this role. Patients described difficulties during follow-up and they felt a lack of continuity of care because a different doctor examined them each time. Interestingly, the figure of reference, the case care manager, was never mentioned within patients' interviews. In fact, a case-manager was intended to be a figure who would orientate and support the patient in follow-up.

"A figure of reference ... I don't know how to call it as a figure ... There is not a figure in the hospital that I referred to. There is no figure. .... I missed this a little and this is a bit like the missing link in my chain "-Patient.5bis

Discussion

Our study showed patients' and healthcare professionals' perceptions of nurses and case manager roles, and interprofessionality within a recently implemented national breast unit pathway. The results seemed contradictory. The Breast Unit patients' perceptions of their role in decision-making and involvement throughout the overall process seemed minimal. Thus, emerging themes depicted the Breast Unit adoption of a model of care still centred on disease and procedure. Moreover, Breast Unit team seemed mostly focused on implementing systems and procedures, to make them work efficiently. This is in contrast with increasing literature on a person-centred care model. The World Health Organization also pointed out how the person and his/her centrality must become a fundamental goal to improve the efficiency of healthcare organizations in all countries (28, 29, 30). Person-centred care has proved to be an approach to treatment possessing positive feedback regarding prevention, safety and clinical effectiveness (30) and conducive to shared decision-making (31). The informed person has more possibilities to act and participate in the treatment process, achieving higher levels of engagement and clinical results (32, 45, 46). Nevertheless, Breast Unit patients' considerations of their role in decision-making and involvement throughout the care process seemed minimal. Although the Breast Unit pathway had an inherent and declared multi professionality, it seemed that the model of care adopted did not allow the creation of a genuine interprofessional collaboration practice. Indeed, the procedure-centred model and the medical language barrier among professionals represent tangible obstacles on interprofessional collaboration (33, 34). Breast Unit fragmentation of care and mono-professional participation in most of the decision-making lead to reflections on a missed interprofessional approach (19).

In contrast with international researches (9, 11, 12, 13, 14), Breast Unit nurses' presence and specialist roles were practically inexistent within patients' representations. From professionals' interviews, the nurses' role seemed more connected to an idea of nursing which is procedural and based solely on practical skills. In this study, oncology advanced nursing practice is mostly perceived as an array of procedures, whereas the interest in the patient-nurse relationship and support was very limited. Nursing as a caring philosophy puts patients at the centre of care; therefore, nurses might have a specific duty in re-framing the model of care, especially in workplaces where such a model is more concerned to support a disease-centred approach (35).

In this study emerged nurses' obstacles in embracing a caring paradigm instead of a task-orientated role. In fact, patients' interviews carried meanings that were not tailored to the uniqueness of the person's experience (29).

Several healthcare team members perceived the use of medical language, especially in MDM, as a barrier. Moreover, patients' perceptions of existing communication issues might be influenced by the organisational habit of using a medical-orientated language (37, 36). Healthcare professionals expressed the need for specific training in communication to ameliorate their skills in patient support and team collaboration. This aspect is in line with studies, which highlight that communication is an important (but often ignored) interprofessional collaborative approach (4). Therefore, the importance of reviewing university curricula needs to be considered, introducing more training in medical school and healthcare professional pathways on inter-

professional communication and to improve collaborative culture too (38, 39).

In our study, the Case Manager role was represented as a very marginal and fragmented one. Although Case Manager (or Oncology Nurse Specialist) is expected according to international recommendations for the Breast Cancer Caring Integrated Pathway (9, 17), in this Breast Unit's official documents this role was not yet included.

Professionals' representations of this role are of a nurse who keeps tracks of the procedures. Besides, it could be inferred that patients' perceived lack of a supporting figure within their pathway might ceased if the Case Manager's role was improved.

Conversely, the central supporting figure in some patients' interviews was a doctor (oncologist or surgeon), which, similarly to a Case Manager role, was sometimes represented as a recurring conversation partner who promptly answered their questions and responded to their needs.

On the other hand, the Case Manager's role of providing consistency and advocacy to patients' pathways is often endangered by excessive workload, lack of organizational support (40, 17) and their missed MDM participation (41).

A workplace where the role of Case Manager is unknown by patients and has little continuity reflects a model of care that is mainly task-oriented instead of emotional support role (42). This last aspect is in contrast to cancer nurses' mandate to integrate care, support patients' emotional burden and alleviate anxiety (42, 44).

Italian nurses are still on a pathway to a fully recognized professionalism with more autonomy and responsibility in a medical-centric system. They are striving to introduce effective advanced roles, which they are prepared for, with the help of government healthcare initiatives (45).

Conclusion

This qualitative study of an Italian Breast Unit Pathway showed an inappropriate and/or underdeveloped Case Manager role and a lack of interdisciplinary culture. In this way, it suggested the need for further research to support a change from a medical-centric paradigm to a person-centred model of care. Such a shift of paradigm can be supported with the introduction of interprofessional education into academic curricula and professional training, and implementing nurses advanced and specialist roles.

Limitations
The small size and methodology adopted for this study did not allow any generalizations, but can suggest further discussions on this topic and developing themes.

Conflict of interest
Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article.

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