

Returning to Work after Cancer - Evidence Review

- Macmillan Cancer Support's [Going back to work](#) page
- Macmillan Cancer Support's [Returning to work: cancer and vocational rehabilitation](#)
- The Institute of Occupational Safety and Health's [Returning to work following cancer](#) page
- The [Working With Cancer](#) web site has research and useful information
- [Returning to work after cancer - an employer's guide](#)
- [Cancer: your rights as an employee](#)
- Loughborough University's report: [Occupational safety and health considerations of returning to work after cancer](#)
- [CLIC Sargent's Going Back to Work after Cancer Treatment](#)
- Teenage Cancer Trust's [Back to Work](#) page
- Brunel University's report: [Time to act: the challenges of working during and after cancer, initiatives in research and practice](#)

Evidence Summary

It's estimated that there are two million people in the UK living with cancer of whom 728,000 are of working age. Cancer survivors are 40% more likely to be unemployed than people who have never had cancer. Cancer survivors fear for job applications, lack opportunities to gradually increase work ability, and face reluctance from employers in hiring them. Researchers have found five phases in the return to sustainable work. In phases one and two survivors are mostly concerned with fighting for life. In phases three and four participants have to adjust and make changes at work before reaching sustainable work in phase five.

Factors helping people return to work include:

- Social support
- Being in good physical health
- A supportive work environment
- A well-informed occupational-health department
- A lack of fatigue
- Helping employees to advocate for themselves
- Telling employees about the relevant policies and procedures
- Helping people returning to work who also have caring responsibilities themselves
- Making accommodations for cancer survivors
- Opportunities to work flexibly
- Telling your colleagues about your cancer
- Time off for medical appointments
- Feeling able to do your job six months after treatment
- Having a white-collar job
- Not having chemotherapy
- Being younger
- Being better-educated

- A good relationship with your employer
- A phased return to work
- Good communication and support between occupational health, line managers and colleagues
- Multi-disciplinary interventions with physical, psychological and vocational components
- Working in a large company as opposed to a small one
- Having less-severe cancer
- Not being in active treatment
- Not having severe side effects from treatment
- High-intensity physical training
- Physical exercise
- Patient information and support at hospital
- Good communication between doctors who treat patients and occupational health
- Having a *higher* BMI
- Not having depression
- Motivation
- Not having lymphoedema
- Not sleeping excessively
- Modification of work duties and performance expectations
- Modification of the physical work environment and/or the provision of adaptive aids/technologies
- Having regular employment
- A guided workbook intervention
- Being employed rather than self-employed
- Using active coping mechanisms
- Better body image
- Maintaining communication with work while you are off sick
- Feeling able to work
- Feeling able to do you old job

Employers think that employee attitude and emotional functioning are important in a successful return to work. Overall managers are positive but some worry that people won't be able to fulfil the demands of their job - female managers worry less than male ones about this. Employers often felt at sea because they had had little experience of people returning to work after cancer.

A lack of knowledge about the effects of treatment and symptoms on work ability and sustainability, particularly in relation to different occupations and work tasks, can result in health professionals offering minimal guidance to patients

Some people say that the priority they give to work changes after having cancer. Women with breast cancer: want to leave the sick role and wish to keep their job; consider whether working is worth the effort; reflect on their capability; have doubts about being accepted in the

workplace after returning. Women with breast cancer felt vulnerable returning to work and only valued help if it addressed this vulnerability

Evidence Review

Berry (Berry, 1992) interviewed 19 cancer survivors and found that the core social process was one of “mobilising social support,” in the workplace. Critical dimensions included: the normalising effect of re-establishing the worker role; the significant effect of sharing the diagnosis with others; the use of stories; the social comparisons which enhanced a sense of wellbeing; and the exploration of priorities.

Sanchez (Sanchez, 2001) studied 250 colorectal cancer survivors. Of the 200 who were employed beforehand 89% returned to work. 31% of the employed survivors experienced poor work adjustment. Survivors in service-related occupations were less likely to return to work than those in white-collar jobs. Employed survivors who reported low co-worker support had more adjustment problems than those who reported high co-worker support. Survivors in poor physical health were more likely to experience poor work adjustment than those in good health.

A literature review by Spelten (Evelien R. Spelten, Sprangers, & Verbeek, 2002) found that while survivors with testicular cancer experienced relatively few problems those with head and neck cancer had more difficulties. Those who performed work requiring strong physical effort also experienced difficulties. The factor most commonly associated with return to work was a supportive work environment.

Verbeek (Verbeek, Spelten, Kammeijer, & Sprangers, 2003) studied the quality of work of occupational physicians. Only 3% had ‘optimal,’ knowledge of cancer and treatment reflecting poor communication with treating physicians. For continuity of care, patient complaints and relations at work performance was optimal for 55%, 78% and 60% of occupational physicians respectively. Overall optimal performance was related to a small, but significant, higher level of satisfaction with care.

Spelten (E. R. Spelten et al., 2003) studied fatigue and return to work in a sample of 235 cancer patients. The rate of return to work increased from 24% at six months, to 64% at 18 months. Fatigue, diagnosis, treatment type, age, gender, depression, physical complaints and workload were all related to the time taken to return to work. Fatigue at six months predicted a longer sick leave.

Main (Main, Nowels, & Cavender, 2005) found that experiences at work after cancer varied in relation to how others responded, changes in productivity, effects of cancer and treatment on work, and feelings about work. Most respondents received little guidance from their physicians about work, and many participants described their cancer as affecting the priority they gave to work relative to other aspects of their lives.

Kinney (Kinney, 2006) recommended that HR departments offer the following to cancer survivors: i) self advocacy ii) better understanding of the organisation’s policies and procedures by the employees iii) more assistance for cancer survivors who are undergoing treatments while caring for sick members of their families

Bouknight (Bouknight, Bradley, & Luo, 2006) studied 416 women with breast cancer. 87% reported that their employer was accommodating to their cancer illness and treatment. Health

status, cancer stage, treatment, job type, heavy lifting on the job, employer accommodation and employer discrimination were all associated with return to work after 12 months. Employer accommodation was associated with return to work at 18 months.

Pryce (Pryce, Munir, & Haslam, 2007) found that opportunities to work flexibly, disclosure to colleagues, difficulties managing fatigue and paid time off to attend medical appointments were all associated with continuing to work during treatment. Correlates of return to work included difficulties managing fatigue, managing the stress of cancer, managing physical changes associated with cancer, received advice from their doctor and a return-to-work meeting with one's employer.

In a focus group of seven female cancer survivors Nachreiner (Nachreiner et al., 2007) found that factors such as co-worker support and job flexibility improved their experiences whereas co-worker and supervisor ignorance about cancer and lack of support made returning to work more stressful.

De Boer (A. G. E. M. De Boer et al., 2008) found that work ability six months after diagnosis strongly predicted return-to-work at 18 months.

Balak (Balak, Roelen, Koopmans, Ten Berge, & Groothoff, 2008) found that length of absence was significantly longer for women with breast cancer who underwent chemotherapy or multimodal treatment. Having trouble reaching over shoulder level significantly delayed partial return to work but no full return to work. The time taken to return to work was principally determined by the type of treatment.

Grunfeld (Grunfeld, Rixon, Eaton, & Cooper, 2008) surveyed 252 organisations. A range of return-to-work services was provided although only 38% provided employees with written information or guidelines about return to work policies or services. Respondents tended to view employee-related factors, such as employee attitude and emotional functioning as key to a successful return to work.

Roelen (Corné A. Roelen, Koopmans, de Graaf, Balak, & Groothoff, 2009) studied sickness-absence data from 1 million workers. The mean length of duration of absence due to breast cancer was 349 days. 37% of absences lasted more than a year and 12% lasted longer than two years.

Hoving (Hoving, Broekhuizen, & Frings-Dresen, 2009) carried out a systematic review of return-to-work interventions for women suffering from breast cancer. Hoving found that interventions focused mainly on improvement of physical, psychological and social recovery but that it was "not clear whether this proportion would have been lower for patients without counselling or exercise, or any other interventions, as three out of four studies did not include a comparison group."

De Boer (De & Frings-dresen, 2009) found that interventions included: a nurse-based intervention in the UK; a group-rehabilitation programme in Sweden; rehabilitation programmes in Germany and a specialist occupational-physician intervention in Holland.

Amir (Amir, Wynn, Whitaker, & Luker, 2009) found that four factors were associated with return to work which were: impact of cancer site; impact of treatment; occupational status; and roles of others.

Amir (Z. Amir & Brocky, 2009) surveyed 797 occupational physicians. Responses suggested opportunities for developing the knowledge base in relation to prognosis and functional outcomes in patients with a cancer diagnosis; instituting information resources on cancer and work for occupational-health physicians and developing communication-skills training. “Most respondents felt managers treated referral to occupational health differently for employees with cancer compared with management referral for employees with other diagnoses, with 45% of respondents indicating referral may take place too late to be effective in securing a return to work.”

Steiner (Steiner, Nowels, & Main, 2010) found that most studies suggested that cancer survivors could return to work without residual disabilities. Cancer site, clinical prognosis, treatment modalities, socio-economic status and attributes of the job itself influenced the likelihood of work return.

Fantoni (Fantoni et al., 2010) studied 379 women and found that after three years 82.1% of them who worked before their diagnosis had gone back to work after a median sick leave of 10.8 months. Older age, lower educational level, chemotherapy, radiotherapy, lymphoedema, psychological or organisational self-perceived constraints related to their former job, and the lack of moral support from work colleagues both limited and delayed return to work.

In 2010 MacDonald (MacDonald, 2010) reported that there were two million people in the UK living with cancer, of whom 728,000 were of working age. According to Macmillan 80% of those in work or education when diagnosed said they were not told about the affect their illness might have on their work or education. Macmillan found that a good relationship with an employer and a phased return to work were two important predictors of a successful adjustment back to work.

Tamminga (S. J. Tamminga, de Boer, Verbeek, & Frings-Dresen, 2010) carried out a systematic review of return-to-work interventions. The most frequently reported work-directed components were encouragement, education or advice about work or work-related subjects (68%), vocational or occupational training (21%) or work accommodations (11%). One intervention fit the shared care model of cancer-survivor care and five interventions enhanced work ability or decreased physical workload.

Yarker (Yarker, Munir, Bains, Kalawsky, & Haslam, 2010) interviewed 26 cancer survivors. One main factor was the central role of communication and support from (and between) occupational health, line managers, and colleagues. Another was the fact that there were two discrete processes or periods of return to work: the experience of return to work during the initial period of return and the experiences of post-return to work. Third, during the post-return period: the importance of the delayed impact of cancer on the ability to work, the lack of follow-up and monitoring and the ‘wear-off,’ effect of empathy and support.

Amir (Ziv Amir et al., 2010) studied managers’ attitudes. These were conceptualised into five factors: fearful attitudes towards cancer survivors; supportive attitudes; line-managers’ perceived burden; maintaining normality; and financial benefits issues. “Overall, line-managers hold relatively positive attitudes towards cancer survivors and are willing to support them in their effort to return to work. However, managers ten to harbour negative attitudes regarding the individual cancer survivors’ ability both to engage in work-related activities and in meeting the demands of employment.” Female managers held more positive attitudes than male managers

toward cancer diagnosis, were less concerned about workload burdens of working with cancer survivors and were more willing to help cancer survivors maintain normality.

de Boer (A. G. de Boer et al., 2011) reviewed the evidence on return-to-work interventions and found: low-quality evidence of similar return-to-work rates for psychological interventions compared to care as usual; very-low-quality evidence to suggest that physical training was no more effective than care as usual; low-quality evidence that functioning-conserving approaches had similar return-to-work rates as more radical treatments and moderate-quality evidence which showed that multidisciplinary interventions involving physical, psychological and vocational components led to higher return-to-work rates than care as usual.

Roelen (C. A. Roelen, Koopmans, Schellart, & van der Beek, 2011) found that employees in high occupational classes started working earlier than those in low occupational classes but the time to a *full* return to work did not differ significantly across occupational classes. Employees working in large companies returned to work earlier than those working in small companies.

Tiedtke (Tiedtke, de Rijk, Donceel, Christiaens, & de Casterlé, 2012) studied women's views about returning to work after breast cancer. She found that four matters were considered: women want to leave the sick role and wish to keep their job; they consider whether working is worth the effort; they reflect on their capability; they have doubts about being accepted in the workplace after returning.

Tamminga (S. J. M. Tamminga, de Boer, Verbeek, & Frings-Dresen, 2012) interviewed 12 breast-cancer survivors. Participants experienced many barriers to, and facilitators of, return to work. Support from a supervisor; importance of work; and physical or psychological side-effects all influenced return to work. Barriers included temperament and personality; "job lock," and societal attitudes. Facilitators included taking care of one's health; skills/coping; and support from family and healthcare professionals. During the initial return-to-work phase physical or psychological side-effects hampered work resumption, while during the post return-to-work phase a lack of understanding from the work environment was a problem. Participants mentioned that guidance from healthcare professionals and information for supervisors and colleagues should be improved.

In a study of 598 patients who were employed at the time of their diagnosis Ross (Ross et al., 2012) found that 75% were still employed at a median of 2.8 years after their diagnosis and 63% were working. Younger and more-recently diagnosed patients were more often employed. Patients with lung, head or neck cancer were least likely to be employed. Advanced cancer and being in active treatment were associated with not having returned to work.

Bains (Bains, Yarker, Amir, Wynn, & Munir, 2012) studied the help health providers gave recovering cancer patients to get back to work. Bains found that lack of knowledge about the effects of treatment and symptoms on work ability and sustainability, particularly in relation to different occupations and work tasks, resulted in providers offering minimal guidance to patients. "Current practices relied on providers' previous experiences with employed patients, rather than a sound evidence base."

Thijs (Thijs et al., 2012) found that rehabilitation using high-intensity physical training was useful for working patients to minimise the decreased ability to work resulting from cancer and its treatment.

Tamminga (S. J. Tamminga et al., 2012) developed an intervention involving the delivery of patient education and support at the hospital and the improvement of communication between the treating physician and the occupational physician. The intervention also involved asking the patient's occupational physician to organise a meeting with the patient and the supervisor to make a concrete, gradual, return-to-work plan. 47% of all eligible patients participated. Nurses delivered the patient education and support in 85% of cases and in all cases a letter was sent to the occupational physician. Patients found the intervention in general very useful and nurses found the intervention feasible to deliver but "it proved difficult to involve the occupational physician."

McKay (McKay, Knott, & Delfabbro, 2013) found that there were a number of drivers which affected people's return to work. These included maintaining normality and regaining identity, which could act positively or negatively, depending on survivors' coping ability and self-awareness. Communication difficulties in the workplace affected emotional and practical support.

Cooper (Cooper, Hankins, Rixon, Eaton, & Grunfeld, 2013) compared return-to-work following treatment for breast, gynaecological, head and neck, and urological cancer. Breast cancer survivors took the longest to return and urology cancers returned the soonest. Earlier return among breast-cancer survivors was predicted by a greater sense of control over their cancer at work and by full-time work. Predictive of a *longer* return among gynaecological-cancer survivors was a belief that cancer treatment may impair ability to work. Among urological cancer survivors constipation was predictive of a longer return to work, whereas undertaking flexible working was predictive of returning sooner. Head-and-neck cancer survivors who perceived greater negative consequences of their cancer took longer to return whereas those reporting better physical functioning returned sooner.

Muijen (Muijen et al., 2013) carried out a systematic review of return to work and employment in cancer survivors. Heavy work and chemotherapy were negatively associated with return to work whereas less-invasive surgery was positively associated with return to work. Breast-cancer survivors had the greatest chance of return to work. Old age, low education and low income were negatively associated with employment. Moderate evidence was found for extensive disease being negatively associated with both return to work and employment, and for being a woman being negatively associated with return to work.

Groeneveld (Groeneveld, de Boer, & Frings-dresen, 2013) studied 10 cancer survivors of working age who had completed a group-based, supervised physical exercise programme. Eight of them returned to work and most said that they had suffered cognitive deficits that had impaired their work performance. According to half of the participants the support in return-to-work from their occupational physician had been insufficient. Most participants thought that physical exercise had contributed to their ability to return to work, primarily by increasing energy levels. Some believed that physical exercise had enhanced their work performance by improving their ability to cope with demanding work. Some respondents found that a supportive work environment stimulated their continuation of physical exercise.

Noeres (Noeres et al., 2013) compared 227 breast-cancer patients with 647 age-matched women. One year after primary surgery, nearly three times as many cancer survivors had left their job compared to the women in the reference group. For breast-cancer survivors a lower level of education, part-time employment, the severity of work-related difficulties and

participation in inpatient rehabilitation correlated significantly with the failure to return to work. The main predictor for not returning to work was found to be age; tumour stage and the severity of side effects of treatment also had an effect.

Luker (Luker, Campbell, Amir, & Davies, 2013) surveyed 382 cancer patients in the UK. Full-time employment fell from 53% prior to diagnosis to 33% after diagnosis and average working hours reduced from 38 to 32 hours a week. Only 48% discussed employment issues with their oncology treatment team, and this was associated with more hours worked. 76% of employers were perceived to have been very supportive and 56% receptive to a phased return-to-work.

Gordon (Gordon et al., 2014) compared 239 adults diagnosed with colorectal cancer to 717 age-matched controls. A significantly higher proportion of those with cancer (27%) had stopped work compared to those with no cancer (8%). Participants with cancer who returned to work took a median of 91 days off work. For participants with cancer, predictors of not working after a year included being older, *lower* BMI, and lower physical well-being. Factors related to delayed work re-entry included: not being university educated; working for an employer with more than 20 employees in a non-professional or managerial role; longer hospital stay; poorer perceived financial status; and having or had chemotherapy.

Islam (Islam et al., 2014) carried out a systematic review of breast-cancer survivors. Barriers to return-to-work included: education; ethnicity; chemotherapy; heavy physical work; poor health; fatigue; depression; and emotional distress. Facilitators included: social-; family-; and employer-support.

Fitch (M. Fitch & Nicoll, 2014) found that patients described a reduction in income and work-related issues dealing with side effects such as fatigue, loss of energy and cognitive changes. Employers said that there were few employees at any one point returning to work after cancer making it challenging for managers to know best how to support them.

Taskila (Taskila, 2014) found that cancer survivors were 40% more likely to be unemployed compared to people without cancer.

Morrison (Morrison & Thomas, 2014) studied 10 female cancer survivors' return-to-work experiences. She found that successful work reintegration was characterised as respectful, collaborative and customised to each survivor's ongoing limitations and variable recovery.

Stergiou-kita (Stergiou-Kita et al., 2014) carried out a qualitative meta-synthesis of survivors' work experiences. She found that cancer diagnosis and treatment represented a major change in people's lives and often resulted in individuals having to leave full-time work while undergoing treatment or participating in rehabilitation. Return to work was found to be a continuous process that involved planning and decision-making with respect to work readiness and symptom management. Nine key factors were identified as relevant to work success: symptoms; work abilities; coping; motivation; family support; workplace support; professional support; type/demands of work; and job flexibility. Issues related to disclosure of one's cancer status and cancer-related impairments were also found to be relevant to survivors' return-to-work experiences.

Knott (Knott et al., 2014) studied barriers to return to work. These included financial pressure; preparedness for work; and lack of confidence. Participants expressed a preference for return-

to-work models that focused on objective and structured assessment while allowing for flexibility to address individual needs.

Tiedtke (Tiedtke, Dierckx de Casterlé, Donceel, & de Rijk, 2015) carried out 14 interviews with women who experienced breast cancer. The key experiences were feeling vulnerable, feeling able to work and need for support. Women experienced support as adequate, only if it addressed their specific vulnerability.

Murray (Murray, Lam, Hubert, McLoughlin, & Sadhra, 2015) studied 194 RAF personnel who survived primary cancer treatment. The median sickness absence before return-to-work was 107 days. Six months after diagnosis 54% of participants had returned to work, while 80% had returned after a year. Time taken to return to work was predicted by: age at diagnosis; rank; trade group; pre-diagnosis sickness absence; site of cancer; treatment modality; and prognosis. Return-to-work at 18 months was predicted by higher rank and having melanoma. Those receiving chemotherapy were significantly less likely to have return-to-work compared to other treatment modalities. Rank, type of cancer, and treatment modality were the most important predictors of return-to-work.

Azarkish (Azarkish, Mirzaii Najmabadi, Latifnejad Roudsari, & Homaei Shandiz, 2015) studied 175 women with breast cancer. Older patients and those with a great deal of work experience were less likely to return to work. Women who had no pain or surgery scar as well as those who had no lymphoedema were more likely to return to work.

Lynch (Lynch, Mihala, Beesley, Wiseman, & Gordon, 2016) found no significant associations between health behaviours at six months and ceasing or reducing work a year after diagnosis. Participants who reported excessive sleep were 2.69 times more likely to reduce work time or retire.

After interviewing 16 cancer survivors, 16 health/vocational service providers and 8 employer representatives Stergiou-Kita (Stergiou-kita, Pritlove, van Eerd, et al., 2016) recommended four types of accommodation: i) graduated return-to-work plans and flexible scheduling ii) modification of work duties and performance expectations iii) retraining and supports at the workplace iv) modification of the physical work environment and/or the provision of adaptive aids/technologies. Processes relevant to ensuring effective accommodations included: i) developing knowledge about accommodations ii) employer's ability to accommodate iii) negotiating reasonable accommodations iv) customising accommodations v) implementing and monitoring accommodation plans. Accommodation challenges included: i) survivors' fears requesting accommodations ii) developing clear and specific accommodations iii) difficult to accommodate jobs and iv) workplace challenges including strained pre-cancer workplace relationships; insufficient/inflexible workplace policies; employer concerns regarding productivity and precedent setting, and limited modified duties.

Nakamura (Nakamura et al., 2016) found that non-regular employment was the variable most likely to negatively affect return to work and job changes in employed patients who underwent treatment for gynaecological cancer.

Stergiou-kita (Stergiou-Kita, Pritlove, Holness, et al., 2016) examined the issue of determining work-readiness. Three key processes were deemed relevant to determining work readiness by health-care providers and survivors: i) assessing functional abilities in relation to job demands ii) identifying survivor strengths and barriers to return to work iii) identifying supports available in

the workplace. Challenges included: i) the complexity of cancer ii) the accuracy of work-readiness determinations and iii) the lack of established processes for addressing work goals.

Schumacher (Schumacher et al., 2017) studied the effectiveness of a guided workbook intervention (WorkPlan) at supporting work-related goals among cancer survivors. “Engaging with the workbook represented a transition towards a future at work and the steps that took place to make that a reality.”

Sun (Sun, Shigaki, & Armer, 2017) carried out a literature review of return-to-work among breast-cancer survivors. All of the 25 studies Sun examined reported reduced work engagement and work ability. Employment status and work performance were associated with a combination of individual factors, work environment, culture and resources.

Torp (Torp, Syse, Paraponaris, & Gudbergsson, 2017) compared self-employed to employed cancer survivors. Torp found that 24% of self-employed cancer survivors had not returned to work, compared to 18% of salaried survivors. 9% of the self-employed had received a disability or early-retirement pension, compared to only 5% of the salaried workers. Compared with salaried workers self-employed people reported significantly more often reduced work hours, negative cancer-related financial and occupational changes, low overall health, low quality of life and low total work ability. The negative effect of self-employment was mediated by reduced work hours and a negative cancer-related financial change.

Duijts (Duijts, Dalton, Lundh, Horsboel, & Johansen, 2017) reviewed the current research and found that six out of 10 cancer survivors were able to return to work within the first year after diagnosis. There was some evidence that multidisciplinary interventions, combining vocational counselling with psycho-education or physical exercises generated a higher return-to-work rate compared to care as usual but “the initiated intervention programmes contributed little to this outcome so far, not in quality nor in quantity.”

Murphy (Murphy, Nguyen, Shin, Sebastian-deutsch, & Frieden, 2017) surveyed health-care staff about their knowledge of the employment-related needs of cancer patients. The longer the staff had worked in oncology the more they knew about disability-related benefits, legislation and programmes. More experienced professionals worked with patients who they reported had a higher number of cancer side effects that “created work difficulties for patients.” The number of side effects was, in turn, positively associated with negative effects of the diagnosis at work. A higher score of negative effects of the cancer diagnosis at work in turn correlated with unwanted consequences of disclosing the cancer at work.

Egmond (Egmond et al., 2017) studied barriers and facilitators for return to work in cancer survivors who had lost their jobs. Cancer survivors feared for job applications, lacked opportunities to gradually increase work ability, and faced reluctance from employers in hiring them.

Duijts (Duijts et al., 2017) interviewed 28 cancer survivors. Work turned out to be a meaningful aspect of their lives and most participants reported a positive attitude towards their job. Social support to return to work, or to continue working, was mainly received from family and friends, but pressure to return to work from the occupational physician was also experienced. Changes in expectations regarding work ability from negative to positive during the treatment process were observed. Those who applied active coping mechanisms felt equipped to deal with difficulties regarding work.

Lee (Lee, Han Sung, Lee, & Lee, 2017) studied 288 women diagnosed with breast cancer. More education and regular endurance exercise were positively associated with return-to-work whilst appetite loss and fatigue were negatively associated with return-to-work. Better body image, better physical function, better existential well-being, and participation in regular endurance and resistance exercise were positively associated with return to work.

Heuser (Heuser et al., 2018) studied 577 women with breast cancer. Education, age, having children, rehabilitation, self-rated health and disease severity all significantly affected return to work.

Caron (Caron, Durand, & Tremblay, 2018) asked survivors about the supportive practices of their supervisors. Three were found to be particularly helpful which were: i) maintaining communication during their absence ii) working with them to structure their return-to-work process before their actual return iii) allowing them flexibility in their schedule for a certain period, particularly at the beginning of the return-to-work process. An omission was lack of follow-up over time.

Petersen (Petersen, Momsen, Stapelfeldt, Olsen, & Nielsen, 2018) studied providers' experiences of employment-related issues. Three major themes emerged from interviews which were: treatment first; work as an integrated component in cancer rehabilitation and challenges in bringing up work issues. In the hospital setting return-to-work was a second priority. Petersen recommended "work issues ought to be systematically presented by providers across sectors as early as possible to support cancer patients' return to work."

Yagil (Yagil, Eshed-Lavi, Carel, & Cohen, 2018) interviewed 26 professionals specialising in physical or mental health working with working-age cancer survivors. Two dimensions emerged from the interviews which were: cancer survivors' motivation to return to work and understanding illness-related implications upon returning to work. Four groups of cancer survivors were identified by the professionals: the realist; the enthusiast; the switcher and the worrier. Social workers and psychologists viewed their role in terms of jointly discussing options and implications with the cancer survivor, while physicians and nurses viewed their role more in terms of providing information and suggestions.

Wolvers (Wolvers, Leensen, Groeneveld, Frings-Dresen, & Boer, 2018) found that lower fatigue and higher value of work; work ability and job self-efficacy of cancer survivors were associated with earlier return-to-work. Work ability and job self-efficacy were key predictors.

Yagil (Yagil, Goldblatt, & Cohen, 2018) examined the relationship between cancer survivors and their supervisors as it affected return-to-work. Four main themes emerged from the research which were: i) congruent supervisor-cancer survivor views regarding personalised/standard management of cancer survivors' returning to work ii) return to work as a team approach iii) commitment and persistence in the face of obstacles iv) supervisor and survivor mutual appreciation. Joint coping was perceived to contribute significantly to the success of return to work. "Training of cancer survivors and supervisors conducted by rehabilitation professionals regarding aspects of the orientation towards return to work is suggested... Organisational acknowledgement of the cancer survivor's value for the organisations supports cancer survivors' return to work."

Brusletto (Brusletto, Torp, Ihlebæk, & Vinje, 2018) found that there were five phases in the return to sustainable work. In phases one and two survivors were mostly concerned with

fighting for life. In phases three and four participants had to adjust and make changes at work before reaching sustainable work in phase five. Overall, the ability to adapt to new circumstances, take advantage of emerging opportunities, and find meaningful occupational activities were crucial.

Ullrich (Ullrich et al., 2018) studied return to work among prostate cancer survivors. Return-to-work after a year was 87% and the median time until return-to-work was 56 days. Patients' perceptions of not being able to work and feeling incapable of returning to their former job were the strongest predictors of not having returned to work after a year. Being diagnosed with more severe cancer and patients' perceptions of not being able to work were the strongest predictors for late return to work.

In a systematic review of studies of colorectal cancer survivors den Bakker (den Bakker et al., 2018) found that (neo)adjuvant therapy, higher age and more comorbidities had a significant negative influence on return to work. A previous period of unemployment, extensive surgical resection and post-operative complications also significantly increased the risk of work disability.

In a Europe-wide systematic review Paltrinieri (Paltrinieri et al., 2018) found that the median interval between diagnosis and documented return to work was 2 years. Personal factors, work-related factors, and cancer-related factors were all associated with return to work and healthcare team interventions facilitated reintegration to work.

Armaou (Armaou, Schumacher, & Grunfeld, 2018) interviewed 23 survivors of urological, breast, gynaecological or bowel cancer. Two themes emerged from the interviews which were: social support as a facilitator of return to work and social comparison as an appraisal of readiness to return to work.

Zamanzadeh (Zamanzadeh, Valizadeh, Rahmani, Zirak, & Huget, 2018) interviewed 20 cancer survivors. Three main categories were identified as important in cancer survivors' experiences of returning to work: i) individual perspectives ii) nature of disease iii) access to support system. "Cancer survivors had limited information about the disease and return to work that made them doubtful about returning to work."

Grunfeld (Grunfeld et al., 2019) found that a guided workbook intervention led to more people returning to work after six months and a year.

Giuliani (Giuliani et al., 2019) studied 130 people with head-and-neck cancer. Pre-treatment employment status, cancer-related symptoms, quality of life and "health utility," were associated with employment outcomes.

Arndt (Arndt et al., 2019) studied 1,558 long-term cancer survivors diagnosed with breast, colorectal or prostate cancer before they were 60. After 8.3 years 63% of all working-age cancer survivors had returned to their old job and 7% had taken up a new job. 17% were granted a disability pension, 6% took early retirement, 4% became unemployed and 1% left the job market. Resumption of work occurred within the first two years after diagnosis in 90% of all returnees. Cancer-related reduction of working hours was reported by 17% among all returnees and 6% quit their job due to cancer within five year after returning to work. The probability of return to work was strongly related to age at diagnosis, tumour stage, education, and occupational class.

Fitch (M. I. Fitch & Nicoll, 2019) interviewed 410 cancer survivors, 60 caregivers and 68 employers. Cancer survivors described a reduction in income, positive and negative experiences returning to work, and work-related issues regarding side effects. Caregivers described loss of concentration and productivity, stress, and a lack of support from co-workers. Employers talked about challenges for managers knowing how best to support cancer survivors as there are few of them of which they were aware. Strategies to achieve success included: in-depth understanding of the issues; consideration of accommodation; communication among stakeholders; education; resources; and financial support.

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