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### Enhancing return to work of cancer patients

Tamminga, S.J.

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## **Chapter 6.**

# **A hospital-based work support intervention to enhance the return to work of employees with cancer – a case study**

S.J. Tamminga, J.H.A.M. Verbeek, A.G.E.M. de Boer, R.M. van der Bij, and  
M.H.W. Frings-Dresen

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## **Abstract**

The purpose of this case study was to describe how the return-to-work process evolved in an employee with cancer in the Netherlands and how a hospital-based work support intervention supported this process. The patient was a 35-year old female employee diagnosed with cervix carcinoma. After surgery, the patient experienced depression, fatigue, fear of recurrence, and low mental working capacity. Communication with the occupational physician was difficult. A social worker at the hospital provided three counselling sessions aimed to support return to work and sent letters to the occupational physician to improve the communication. The support by the social worker helped the patient to resume work gradually and the sending of information from the treating physician and social worker improved the communication with the occupational physician. This resulted in the patient being able to achieve lasting return to work. This hospital-based work support intervention was highly valued by the patient and could be an important addition to usual psycho-oncological care for employees with cancer.

Trial registration: NTR1658

## **Introduction**

The return to work of patients diagnosed with cancer is increasingly recognised as a problem that needs more attention in both the occupational health field as in oncology. It will be even more pressing in the future as employees with cancer will become a frequent phenomenon in the workplace due the increased survival rates of cancer, the ageing of the working population, and the fact that people have to work longer before retiring.<sup>1</sup>

The increased survival rates of cancer imply that cancer will become a chronic disease but involve in general a lower quality of life<sup>2</sup> due to long-term side effects such as depression, fatigue, and distress.<sup>3</sup> These symptoms impact survivors' capabilities to resume their 'normal' life after cancer treatment. For employees with cancer, an important part of resuming their 'normal' life is to return to work, because work, takes one's mind off of one's illness,<sup>4</sup> reduces financial problems,<sup>5</sup> is often perceived as going 'back to normal',<sup>6</sup> and work is associated with the quality of life of cancer patients.<sup>7</sup>

Unfortunately, not all employees with cancer do return to work. In a meta-analysis, the risk of unemployment was 37% higher in cancer patients compared to healthy controls.<sup>8</sup> Employees with cancer also suffer from lower work productivity compared to employees without cancer.<sup>9</sup> <sup>10</sup> Furthermore, many experience difficulties with return to work, such as an insensitive work environment,<sup>11</sup> discrimination,<sup>11</sup> <sup>12</sup> or how to overcome symptoms such as fatigue, concentration problems, and depression.<sup>11</sup> <sup>13</sup>

To support employees with cancer upon return to work, we developed a hospital-based work support intervention with the primary aim of enhancing return to work while at least maintaining and hopefully increasing their quality of life.<sup>14</sup> The intervention is currently under evaluation in a multi-centre randomised controlled trial for which the medical ethics committee of the Academic Medical Center gave approval.

Return to work after an illness is a complex process facilitated or hindered by a number of factors (e.g. work ability, physical workload) that involves various stakeholders (e.g. colleagues, supervisors), and health care professionals (treating physician, occupational physician).<sup>15</sup> The whole process is guided by complex disability legalisation and social security that are deeply embedded in a cultural context. Elaboration and elucidation of facilitating and hindering factors will help us to better understand which mechanism operates in the return-to-work process of employees with cancer.

The institutional context of a national social security system influences the return to work of sick-listed employees. Therefore, to be able to understand how a return-to-work process evolved in an employee who was sick-listed due to cancer, it is necessary to know how the social security system protects employees with cancer that are incapacitated for work. In the Netherlands health insurance is not related to an employment contract and employees who are sick-listed have social care and financial protection. In the first two years of sick leave, the Improved Gatekeepers Act covers insurance of sick-listed employees against wage loss, which is paid by the employer and is at least 70% of their wage but often 100% during the first year of sick leave. During this first two years of sick leave, a patient cannot be dismissed for health reasons. The occupational physician will make a disability evaluation with regard to the employee's own work situation and will independently advise the employer and employee on return- to-work issues. After two years of sick leave, an independent insurance

physician will formally assess employee's ability to work. Based on this evaluation, the patient can be awarded a disability pension, which is paid by the government and the employer can then terminate the employment contract. In addition, the treating physician who treats patients in terms of a disease is strictly distinguished from the occupational physician who provides return-to-work management and strictly distinguished from the insurance physician who formally assesses disability for work.

The purpose of this case study was to describe how a return-to-work process evolved in an employee with cancer and how a hospital-based work support intervention supported this process. This case study describes a successful participant of a multi-centre randomised controlled trial (trial number: NTR1658).

#### Description of the multicentre randomised controlled trial

This case study describes a successful return to work of a participant of our multicentre randomised controlled trial. The intervention aims to enhance the return to work with the maintenance of quality of life in employees with cancer.<sup>14</sup> Eligible patients were randomised and received either usual care or the hospital-based work support intervention. Quality of life was measured with all subscales of the Short Form-36 (SF-36).<sup>2</sup> Secondary outcomes were work ability as measured with the Work Ability Index (WAI),<sup>16</sup> work limitations as measured with the Work Limitation Questionnaire (WLQ),<sup>17</sup> and costs. In addition, we measured fatigue with the Multidimensional Fatigue Index (MFI)<sup>18</sup> and depression with the Centre for Epidemiologic Studies for Depression Scale (CES-D)<sup>19</sup> as these are important prognostic factors for return to work.<sup>13</sup> Acceptable measures of validity and reliability have been reported for these questionnaires for use at group level.

#### Description of the hospital-based work support intervention

The hospital-based work support intervention is based on providing patient education, advice, and support at the hospital as part of psycho-oncology care, communication between stakeholders, and making a concrete gradual return-to-work plan in collaboration with all stakeholders.<sup>14</sup> The intervention is carried out individually. Furthermore, the time frame of the intervention is adapted to the cancer diagnosis,

treatment, the preference of the participant, and the organisation of the psycho-oncological care at the hospital department.

The first face-to-face meeting is planned a few weeks after diagnosis and the last is planned at a maximum of 14 months after its start. To improve the communication between stakeholders, two letters from the treating physician and one from the social worker are sent to the occupational physician. These letters contain medical information such as diagnosis, prognosis, treatment plan, and side-effects of treatment. In the Netherlands, patients must give their consent to allow medical information to be sent from a treating physician to an occupational physician. The social worker has asked for this consent during the first meeting. General information about the study is attached to this letter and we have asked the occupational physician to organise a meeting between supervisor, participant, and themselves to make a concrete return-to-work plan.

The case study was based upon triangulation of: social workers' reports of face-to-face meetings and contact by e-mail and telephone, participant's self-reported questionnaires filled in at baseline and at 6 and 12 months follow-up, and correspondence between the treating physician/social worker and the occupational physician.

## **Description of the case**

### Situation at first contact

#### *Medical and personal situation*

The patient was a 35-year-old female diagnosed with a cervix carcinoma stage I B1 who was referred to the department of gynaecology of the Academic Medical Center in Amsterdam, the Netherlands in December 2009. She gave written informed consent to participate in our study in January 2010, a few weeks after diagnosis and before the start of medical treatment. Additionally, she gave written informed consent to undertake and publish this case study in July 2011. As part of the ongoing study, she filled in questionnaires to assess medical, personal, work, and psychosocial characteristics<sup>2 16 18 19</sup> that were deemed important for return to work (Table 1).

Cancer of the cervix is a serious potential life threatening medical condition that needs extensive surgical treatment in which the womb, adjacent lymph nodes, and

sometimes the ovaries are removed. Stage 1 B1 means that the cancerous changes are confined to the cervix with little invasion and spread to the surrounding tissues, but there are no metastases. The treatment is with the intent to cure and consist of surgery and adjuvant radiotherapy if indicated by the outcome of the surgery. In addition to the usual side effects of cancer and cancer treatment such as fatigue and depression, one of the more specific side-effects of this operation is lymphoedema of the lower limbs.<sup>20</sup>

When one of us [ST] first met her, she presented as an independent and strong woman who attributed great meaning to her work and who was very worried about not being able to work. Her scores on the MFI, CES-D, and on the SF-36, indicated that she experienced serious fatigue, scored above the clinical cut-off score for depression<sup>19</sup> and did not feel well in general. She also felt limited in an emotional sense with subsequent limitations in social functioning. Her ratings of quality of life were rather low compared to a benchmark of cancer patients before the start of treatment.<sup>2</sup> In contrast, she did not report problems with physical functioning nor pain (Table 1). The patient reported suffering from hypoglycaemia and back, neck, and hip problems. She lived with her husband and did not have children. Both contributed to their income, which was above average.

### *Work situation*

The patient completed intermediate vocational education and worked for 10 years. At the time of diagnosis, she worked as a planning engineer during the past 6 years for 40 hours a week with regular paid overtime. She was employed by a large company (>100 employees) on a permanent basis. When one of us [ST] first met her, she was sick-listed for 20 days. She rated her physical workload as 4 (range 0-21),<sup>21</sup> because some tasks required reaching and lifting heavy objects but she did not regard this as a high physical workload. The patient felt that her relationship with her supervisor and colleagues was very good. She disclosed the cancer diagnosis and treatment to them without any problems a few days after she received the diagnosis. Work was very important to her as indicated by her rating of 78 of the importance of work on a Visual Analogue Scale (VAS-scale) ranging from 0 (least important) to 100 (most important). She rated her current overall work ability as 2 on the WAI, ranging from 0 (worse) to 10 (best).<sup>16</sup> This assessment was especially based on a low rating of her mental work ability, which she

rated as 'low'. Her mental work ability was in line with her level of depression, low general mental health, and role limitations due to emotional problems. She did not report problems with physical work demands (Table 1).

**Table 1.** Outcome of self-reported questionnaires at baseline and at 6 and 12 months follow-up.

Patient characteristics	Baseline	6 months	12 months
<b>Indicators for work capacity</b>			
Overall work ability <sup>1</sup>	2	4	6
Work ability in relation to physical demands <sup>2</sup>	4	2	4
Work ability in relation to mental demands <sup>2</sup>	2	2	3
Overall importance of work <sup>3</sup>	78	100	64
<b>Indicators for mental and physical health</b>			
Overall quality of life <sup>3</sup>	49	67	62
Depression <sup>6</sup>	17	31	17
General fatigue <sup>5</sup>	16	12	13
Mental health <sup>4</sup>	56	48	40
Vitality <sup>4</sup>	50	40	35
General health <sup>4</sup>	35	65	60
Bodily pain <sup>4</sup>	90	100	77
Physical functioning <sup>4</sup>	100	85	95
<b>Indicators of limitations and restrictions of participation</b>			
Social functioning <sup>4</sup>	63	100	100
Role-emotional <sup>4</sup>	0	0	33
Role-physical <sup>4</sup>	0	0	75

1. Range 0-10; higher score means higher work ability

2. 5-point scale; higher score means higher work ability

3. Range 0-100; measured on VAS-scale higher score means higher quality of life

4. Subscale SF-36; range 0-100; higher score means less complaints

5. Subscale general fatigue of the Multidimensional Fatigue Inventory (MIF); range 5-25; higher score means more fatigue

6. Centre for Epidemiologic Studies for Depression Scale CES-D; range 0-60; higher score means higher level of depression

### *Hospital-based work support intervention*

The hospital-based work support intervention was part of a multi-centre randomised controlled trial with the aim of enhancing return to work with the maintenance of quality of life in employees with cancer. In this particular case, the medical social worker [RvdB] of the Academic Medical Center carried out the hospital-based work support intervention with support from the research project. The intervention started in February 2010, and ended in August 2011 (Figure 1) and consisted of three face-to-face meetings with the social worker of 25 to 50 minutes each and a number of contacts

by telephone and e-mail. These meetings were aimed at diagnosing return-to-work problems and to support the patient with solving them. The social worker provided the patient with information about social security and legal rights. With the patient's consent, letters with medical information were sent to the occupational physician to improve the communication with the occupational physician.

### Situation at follow-up

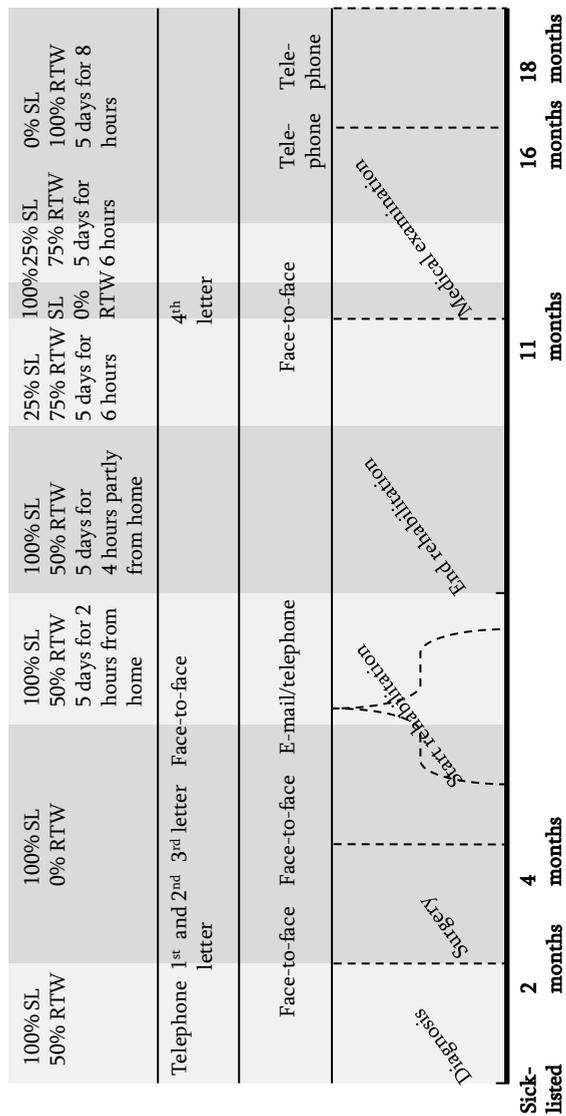
#### *Medical and personal situation*

The patient underwent major surgery in February 2010 (radical hysterectomy according to the Wertheim-Okabayashi technique) in which the cancer of the cervix was radically removed. She was admitted to the hospital for ten days. Surgery was successful and there was no indication for further treatment. As a direct side-effect of the major surgery she suffered from lymphoedema in her legs.

After 5 months of sick leave in July 2010, the patient started with an outpatient rehabilitation program for 4 months for 2 mornings a week aimed at improving her physical condition and reducing the lymphoedema in her legs (Figure 1).

In January 2011, thirteen months after diagnosis, she suffered from pain in her stomach and unaccountable blood loss. Therefore, medical examination under full anaesthetic took place to examine if the complaints were an indication of recurrence of the cancer. This examination revealed that there was no sign of recurrence.

About six months after diagnosis, the patient filled in the various questionnaires again (e.g. MFI, SF-36, CES-D, and WAI). This assessment indicated that depression and emotional limitations worsened compared to baseline (Table 1). Her level of feelings of depression was high (score = 31) and beyond the cut-off point for clinical depression (score = 17)<sup>19</sup> and mental health worsened. In contrast, all other indicators of health and work capacity improved, even though some only slightly (Table 1). The change score on the VAS quality of life indicated a clinically meaningful improvement<sup>22</sup> as well as the change score on the social functioning subscale of the SF-36.<sup>2</sup>



**Figure 1.** return-to-work process and intervention.  
Abbreviations: SL = Sick-listed; RTW = return-to-work

### *Work situation*

The patient reported sick for the first time on the 20<sup>th</sup> of December 2009 for 100% of the working time, returned to work full-time, and was not officially sick listed anymore after 14 months (Figure 1). The patient had a phased return to work. She worked before surgery although sick-listed, and after surgery she was sick-listed for 5 months in which she did not work due to physical and psychological side-effects of the cancer diagnosis and major surgery. Thereafter she had a phased return to work for 14 months including different tasks, working hours, responsibilities, workplace, and the official percentage of sick leave gradually decreased. An extra person was employed to assist her. Her work situation did show some relapses in work performance due to medical examination under full anaesthetic, fear of recurrence, problems with lymphoedema in her legs, and due to concentration and stomach problems.

The patient assessed her overall work ability at 6 months follow-up as increased compared to baseline but work ability for mental work remained low and for physical work slightly decreased (Table 1). This concurred with increased feelings of depression and not feeling up to mental work demands. Nevertheless, she found her work at 6 months follow-up even more important than at any other moments of measurement (Table 1).

### *Hospital-based work support intervention*

The social worker met the patient for the first time when she was admitted to the hospital for surgery in February 2010. She told that work was very important and that she worked extremely long days. Although she was sick-listed, she was at work before surgery because there was so much work to do and because she appreciated the social contact. She told that she experienced a high work pressure and high mental workload because two persons should actually do her job. The social worker told her about the rights and obligations of sick-listed employees in the Netherlands and gave an informational leaflet about cancer and work.<sup>23</sup> In addition, the social worker discussed return to work after major surgery for a cervix carcinoma and gave an educational leaflet that consisted of 10 steps of advice, which provided support, graded activity, and goal setting for returning to work after sickness absence.<sup>24</sup> Even though the patient's job required a good mental and physical working capacity, the social worker assessed that

she would be able to return to work a few months after surgery because she appeared to recover well and no additional cancer treatment was needed. Therefore, the social worker and the patient agreed to meet again a few months later.

With the patient's consent, the treating physician sent a letter to her occupational physician with information about diagnosis, treatment, and side effects in February 2010 and a second letter in March 2010.

The social worker met the patient for the second time in April 2010 at the hospital department while she was still full-time on sick-listed. She told her social worker that she suffered from severe fatigue, concentration problems, that she had pain in her back, neck, and left hip, and that her physical condition was poor. She explained that her recovery did not go as well as she expected and that she had problems with resuming work: *'Due to my concentration problems, I am barely able to sit behind my computer for one or two hours and the lymphoedema in my leg gets worse after sitting for some time. Due to the pain in my back, neck, and left hip I am not able to reach and lift heavy objects.'* For that reason, the social worker advised to resume work at a very slow pace and to gradually increase work at the computer. The social worker advised not to reach or lift heavy objects. This information was also sent to the patient's occupational physician.

The patient contacted the social worker a few times by e-mail and telephone between July and October 2010 because she disagreed with her occupational physician: *'My occupational physician thinks that I am able to work for two mornings a week. Including travelling time from home to work it means that I am away from home for at least six hours. How am I supposed to do that? He did not even ask about my medical condition and I only spoke to him on the phone. He judged my abilities to work solely on the basis of the time since surgery.'* Furthermore, she feared a cancer recurrence and she was afraid of the high work pressure when returning to work.

She thought that her occupational physician did not understand her situation. The social worker advised to ask for a face-to-face appointment with the occupational physician. This turned out to be successful and misunderstanding between the patient and the occupational physician were solved. The occupational physician and the patient jointly made a gradual work resumption plan. She started from August 2010 on for 2 hours a day from home to avoid the long time for commuting. This was increased to 4

hours a day from October 2010 on, partly from home, and from November 2010 on for 6 hours a day. In the mean time an extra person was employed to assist her. The patient was relieved that her occupational physician now understood her situation.

When she was admitted to the hospital in January 2011 for a medical examination under full anaesthetic, she met the social worker for the third time. Because of a strong fear of cancer recurrence return to work was not further discussed before the results of the examination were known. A cancer recurrence would set a different perspective on return to work. Fortunately, the outcome of medical examination revealed that there was no sign of a cancer recurrence.

The patient approached her social worker by telephone in June 2011 because she still felt that her occupational physician misunderstood her limited work capacity. In addition to earlier problems, she also experienced stomach problems that led to sleeping problems. Even though the outcome of the medical examination was good, she remained afraid for a recurrence. The social worker asked the treating physician to send an extra letter to her occupational physician that described the outcome of the medical examination under anaesthetics with the intent of showing the seriousness of this medical examination and its side-effects.

During the last contact by telephone in August 2011, the social worker found that the patient sounded bright and optimistic. She said that she was happy that her supervisor accepted that she was not able to work on her pre-diagnosis level anymore and that an extra co-worker was employed who assisted her. On the other hand, she still experienced problems with lymphoedema in her legs and found it difficult to accept that she was not able to work at her pre-diagnosis level anymore.

#### Situation at end of follow-up

##### *Medical and personal situation*

The patient's further medical recovery was uneventful even though she experienced problems with lymphoedema in her legs.

At 12 months after diagnosis, the patient was still depressed and felt limited in her emotional functioning even though she improved since baseline and half a year follow-up. However, her levels on role limitations due to physical health, general health, social

functioning, and overall quality of life were much improved and comparable to a general population benchmark (Table 1).<sup>2</sup>

### *Work situation*

Her work situation at the end of follow-up in August 2011 was good. She returned to work full-time in February 2011 and was not officially sick listed anymore. However, she was not able to work on her pre-diagnosis level, which she found difficult to accept. This was overcome by employing an extra person that assisted her.

The patient's confidence in her ability to work increased over time, which was probably reinforced by a positive experience of gradual work resumption. In addition, her levels on work productivity as measured with the Work Limitation Questionnaire<sup>17</sup> ranging from 0 (no limitations) to 100 (severe limitations) were 20 on time management demands, 42 on physical demands, 44 on mental-interpersonal demands, and 35 on output demands, indicated a moderate loss of work productivity especially for mental-interpersonal and physical demands which is in line with the rather low levels on work ability in relation to mental and physical work demands (Table 1).

The value the patient attached to work decreased by almost 50% at the end of follow-up, which illustrated that the experience of cancer can fundamentally change the position of work in one's life (Table 1).<sup>25</sup>

### *Evaluation of the hospital-based work support intervention*

The patient evaluated the hospital-based work support intervention of the social worker on a self-reported questionnaire as very useful: '*The support, information about rights of sick-listed employees, and discussing return to work prevented me from returning to work too early*'. However, she stated that it would have been more useful for her if there had been contact with the social worker immediately after the first visit at the outpatient clinic instead of a month later. This was because she felt a lot of pressure to return to work and because at that time there was no one else who took over her job. She stated that: '*The impact of the cancer diagnosis was less than the impact of being forced to stop working. At the time of diagnosis I thought that it was not possible to stop working for at least three months*'. She found the social worker apt for this task and she appreciated that the meetings were held at the hospital. She found the

informational leaflet very useful and she rated the 10 steps of advice with an 8 on a scale from 0 (not useful) to 10 (very useful). She only found making a return-to-work plan difficult because the return-to-work plans were adjusted regularly and were not evaluated often enough.

In her opinion there was still room for improvement for her supervisor and occupational physician. She doubted the competence of the occupational physician due to a lack of knowledge of the impact of cancer on work and due to communicating by telephone only. Moreover, she felt offended by the fact that at first her occupational physician was of the opinion that the medical examinations were only unpleasant, while she feared recurrence of cancer.

### **Discussion**

This case study described how a return-to-work process evolved in an employee with cancer and illustrated the hindrances to resume work such as depression, fear of recurrence, concentration problems, fatigue, and lymphoedema. This case study also described how a hospital-based work support intervention supported an employee with cancer in this process. It illustrated that the intervention was feasible to carry out and appreciated by the patient and that the patient achieved a lasting return to work with an increased quality of life rating.

The patient of this case study was in some aspects not a typical case. For instance, the patient was of the opinion that the impact of the cancer diagnosis was less compared to not being able to work which is not representative for employees diagnosed with cancer. The social worker thought that the patient's response was caused by her worries about the consequences of cancer for her functioning rather than the cancer diagnosis itself. In addition, the social worker thought that this was not a response to feeling unable to deal with a cancer diagnosis but that it was caused by the fact that work was very important for the patient. The patient organised her life in such a way that she spent very much time at work. In contrast, the patient was in other aspects a typical case such as the phased return to work and support from supervisor and colleagues.

This patient was at a relatively high risk of long sick leave and subsequent job loss. The following factors presented in this patient were reported in the literature to delay return to work based on prognostic research: low work ability,<sup>26</sup> cancer type (i.e. cervix

carcinoma I 1B),<sup>13</sup> depression, fatigue,<sup>13</sup> and low quality of vocational rehabilitation by occupational physician.<sup>27</sup> In addition, the male work culture is likely to have resulted in lack of support in this case, as she was not able to provide the required physical strengths. As a result, she lost her pivotal role in the company, which she had difficulties to accept. In this case the high pre-diagnosis work demands seemed to be particular hindrance for return to work but pre-diagnosis stress at work were found to increase time to return to work.<sup>13</sup> This could be because high pre-diagnosis work demands can increase the feeling to be needed at work and thus enhanced return to work. At the group level the enhancing and delaying effect of pre-diagnosis stressful work demands would then be cancelled out.

Even though there are many studies about prognostic factors for return to work, their clinical application is limited. What is urgently needed is to translate the findings of prognostic research into clinical prediction tool that can be used to make a clinical assessment of the risk of long term sick leave and job loss.<sup>28</sup> With such a prediction tool health care providers can focus on patients that most need support.

The hospital-based work support intervention was successful in supporting this patient in her return-to-work process by providing information about rights and obligations of sick-listed employees, information about cancer and work, and by providing support when and how to return to work. However, the timing of the hospital-based work support intervention was not optimal in this particular case because the patient thought that it would have been more useful for her if the hospital-based work support intervention would have started immediately after the first visit to the gynaecologist at the outpatient clinic (Figure 1). Few interventions, aimed at enhancing return to work, have been reported in the literature and hardly any have been evaluated in randomised controlled trials.<sup>29 30</sup> This stresses the need for developing and evaluating interventions aimed at enhancing return-to-work in employees with cancer.

In this case it turned out that difficulties with return to work were not optimally assessed because recovery seemed to go well at first and the relationship with her supervisor and her colleagues appeared good. Then the recovery process was negatively influenced by the patient's fear of cancer recurrence, fear of pre-diagnosis work pressure, and depression. It seemed that depression in this patient was to some extent

overlooked and might have needed more attention. An answer to this problem may be to screen each patient on depression and provide feedback to the social worker on patient's depression score. Depression as co-morbidity is a strong impediment to resume work in many diseases. Treatment of depression has been reported successful in patients with cancer.<sup>31</sup> Moreover, problems were enhanced by the miscommunication between her and her occupational physician who judged her working capacity at first only on the time that had past since surgery without taking into account her emotional and physical recovery. Even though, communication between the health care professionals was optimised by sending letters, this turned out not to be enough. The advice of the social worker to communicate face-to-face with the occupational physician was much more successful in that respect. For return-to-work interventions, it would be helpful to develop better models for communication between health care providers.

Lessons learned from this case study include the importance of a targeted yet flexible intervention, the importance of timing of the intervention, the complex process of return to work, importance of emotional recovery after a cancer diagnosis, and informing the occupational physician sufficiently about patient's situation.

In order to be able to provide a targeted but flexible intervention we should be able to screen what the most appropriate time is to intervene and what the content of the intervention for each particular employee with cancer should look like. Furthermore, in order to better deal with the complexity of a return-to-work process we need to be able to regularly evaluate the return-to-work process and regularly adjust a return-to-work plan.

### **Summary**

In summary, this case study illustrated how a return-to-work process evolved in an employee with cancer and illustrated how a hospital-based work support intervention supported an employee in this process. The patient was a 35-year old female employee diagnosed with cervix carcinoma and resulting cancer-related symptoms of fatigue, depression, and reduced work ability. She also had difficulties with her occupational physician. A social worker at the hospital provided three counselling sessions aimed to support return to work as part of psycho-oncological care and improved communication with the occupational physician. The support by the social worker helped the patient to

resume work gradually and the sending of information from the treating physician and social worker improved the communication with the occupational physician. This resulted in the patient being able to achieve lasting return to work. The hospital-based work support intervention was highly valued by the patient. A hospital-based intervention aimed at supporting return to work in employees with cancer could be an important addition to usual psycho-oncological care.

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