Received: 20 September 2017 | Revised: 14 January 2018 | Accepted: 15 January 2018

DOI: 10.1002/pon.4649

PAPER

WILEY

Health care professionals' perspective on return to work in cancer survivors

Dana Yagil | Nofar Eshed-Lavi | Rafi Carel | Miri Cohen

Faculty of Social Welfare and Health Sciences, University of Haifa, Haifa, Israel

Correspondence
Dana Yagil, University of Haifa, Mount Carmel, Haifa 31905, Israel.
Email: dyagil@research.haifa.ac.il

Funding information
Israel National Institute of Health Policy and Health Services Research, Grant/Award Number: 2016/15

Abstract

Objective: Health care professionals play a significant role in cancer survivors' decisions regarding return to work (RTW). While there is ample research about cancer survivors' views on RTW, little is known about the views of the professionals who accompany them from diagnosis to recovery. The study explores professionals' perceptions of cancer survivors in the RTW context, as well as their views about their own role in the process.

Methods: In-depth interviews (N = 26) with professionals specializing in physical or mental health working with working-age cancer survivors: occupational physicians, oncologists, oncology nurses, social workers, and psychologists specializing in oncology.

Results: An analysis of the interviews revealed 2 prominent perceptual dimensions among professionals: the cancer survivor's motivation to RTW and understanding illness-related implications upon returning to work. The 2 dimensions imply the following 4 groups of cancer survivors in the RTW context, as viewed by health professionals: the "realist," the "enthusiast," the "switcher," and the "worrier." The results also indicate that social workers and psychologists view their role in terms of jointly discussing options and implications with the cancer survivor, while physicians and nurses view their role more in terms of providing information and suggestions.

Conclusions: The training of professionals should increase awareness of the assumptions they make about cancer survivors in regard to RTW. Additionally, training might elaborate professionals' view of their role in the interaction with cancer survivors regarding RTW.

KEYWORDS

cancer survivors, health care professionals, oncology, perceptions, return to work

1 | INTRODUCTION

Many cancer survivors experience both physical and emotional adjustment difficulties when returning to work,[1,2] which may also affect their performance at work.[3] Studies have shown that long-term post-treatment symptoms, especially fatigue,[4,5] cognitive problems,[2] depression and anxiety symptoms[6] are associated with a longer time taken to return to work (RTW) or not returning at all. At the same time, studies have shown that work plays an important role in the lives of cancer survivors[7-11] and is positively related to wellbeing and quality of life.[12]

RTW can best be regarded as a multidisciplinary process,[13] involving several parties, besides the employee. Cancer survivors interact with multiple health care professionals specializing in physical or mental health who can potentially contribute to RTW.[14] While there is prior research regarding cancer survivors' personal views on RTW,[15-17] little is known about the views of the professionals who accompany them along the way, starting with the diagnosis, during treatments and through post-treatments and follow-ups. Such research is important because health professionals' views regarding RTW, as well as the guidance and support they provide, significantly affect both cancer survivors' decisions about RTW and the success of the process.[18-20] Physicians seem to be influenced, regarding their decision to discuss various health issues with their patients or even regarding their professional behavior, by their own beliefs and attitudes[21] about patients' characteristics.[22-25] In addition, health care professionals' views regarding RTW may be affected by their personal

beliefs about the merit of working for cancer survivors and their perceptions about their own role in the process.[23]

Because the health care professional's opinion may be a major factor in the cancer survivor's decision regarding work—whether in relation to trying to return to the same job, changing jobs, or stopping to work completely,[26] it is important to understand the different aspects of health care professionals' views regarding RTW, beyond their clinical evaluation of the cancer survivor's health situation. Understanding how health care professionals involved in the RTW process perceive cancer survivors can contribute to the training of these professionals—specifically, regarding self-awareness about their perceptions and the subsequent effects on their behaviour. Therefore, the study's aim was to explore health care professionals' views associated with RTW. The major research questions were as follows: (1) How do health care professionals perceive cancer survivors in the RTW context? and (2) How do health care professionals view their own role in the RTW process?

2 | BACKGROUND OF THE STUDY

The Israeli national health insurance provides full coverage for all cancer-treatment modalities for Israeli citizens. Oncology care is provided in oncology institutes or centers located within the main public hospitals in Israel. In accordance with the interdisciplinary framework of care suggested by various cancer partnerships and organizations, ie,[27,28] oncology care is provided within an interdisciplinary framework. The interdisciplinary teams mainly consist of oncology and radiology specialists, nurses, social workers, and psychologists. Social workers meet with most cancer survivors, at least for psycho-social evaluation, but a substantial number of cancer survivors also receive psycho-social care, individually or in groups. Psychologists treat relatively fewer cancer survivors, upon referral from the multi-professional staff. Occupational health services provide pre-employment examinations, periodical surveillance examinations, and work capacity evaluations of individuals after injuries or due to illnesses, including RTW evaluations of cancer survivors. In the latter case, the occupational physician determines the work ability of the concerned person in relation to the job demands and after consulting with administrative and professional units in the specific work site.

3 | METHODS

This was a qualitative study, which attempted to gain an in-depth understanding of the subjective meaning of health care professionals' views about RTW of cancer survivors.[29]

3.1 | Participants

The sample was composed of professionals specializing in physical or mental health, working in public hospitals with working age cancer survivors. To gain a comprehensive view of professionals' perceptions, the study included 26 participants representing various types of responsibilities regarding cancer survivors: Occupational physicians (N = 5); oncologists (4 seniors and 2 interns); social workers (N = 5) and psychologists (N = 5) specializing in psycho-oncology; and oncology nurses (N = 5). Table 1 presents participants' details. Participants were recruited using the "snowball method," beginning with the authors' professional connections. The final sample size was determined by the theoretical saturation principle.[30]

3.2 | Data collection

Data were collected through in-depth individual semi-structured telephone interviews, conducted by N. E. L., a graduate student in the School of Social Work who has received training in qualitative methodology as part of her academic training. Participation in the study was voluntary, and at the beginning of the interview, participants were told they could stop the interview at any time. The interviewers encouraged participants to recount their stories from a reflective perspective.[31] The semi-structured interview guide included open questions that covered several key issues derived from the research questions. Sample questions were: "In your opinion, what is the meaning of RTW for cancer survivors?"; "How do you view your role regarding the RTW of cancer survivors?" Interviews lasted approximately 45 minutes, were audio-recorded, and were later transcribed verbatim. The study was approved by the University of Haifa's Faculty of Welfare and Health Sciences' Ethics Committee (No. 279/17).

3.3 | Data analysis

Grounded theory techniques were used in the analysis as these can be used to uncover and understand what lies behind any phenomenon about which little yet is known.[32,33] Data were analyzed by D.Y. and M. C. The interview analysis included 3 stages[33]: (1) Open coding, wherein each interview was read separately, so as to familiarize the researcher with each participant's narrative, and to create codes.; (2) Axial coding, wherein codes were sorted and synthesized into categories, while trying to identify subcategories and find relationships between the different categories; and (3) Integration, in which connections were made between similar or opposing categories of the different interviews and themes, consolidating them into main themes, leading to the study findings. Then, the data were organized based on themes revealed in participants' narratives, and separate interpretive notes were compiled from the descriptive narratives. Next, D. Y. and M. C. discussed gaps and looked for agreement regarding theme content and interpretation of meaning.

4 | RESULTS

4.1 | Salient characteristics of cancer survivors regarding RTW

The results indicate 2 central dimensions in professionals' views of cancer survivors in regard to RTW: *motivation to* RTW and *understanding illness implications*.

4.1.1 | Motivation to work

Professionals described their impressions about the extent to which cancer survivors are motivated to resume working, either in their

TABLE 1 Participants' characteristics

	Profession	Gender	Age	Tenure (Years)
1	Occupational physician	Male	63	16
2	Occupational physician	Male	61	25
3	Occupational physician	Male	41	8
4	Occupational physician	Male	58	20
5	Occupational physician	Female	56	20
6	Oncologist	Female	59	31
7	Oncologist	Male	52	20
8	Oncologist	Female	60	30
9	Oncologist	Male	50	10
10	Oncologist (intern)	Female	33	5
11	Oncologist (intern)	Female	37	6
12	Social worker	Female	39	15
13	Social worker	Female	47	18
14	Social worker	Female	47	2
15	Social worker	Female	52	19
16	Social worker	Female	36	10
17	Nurse	Female	34	5
18	Nurse	Female	39	14
19	Nurse	Female	40	17
20	Nurse	Female	43	20
21	Nurse	Female	55	25
22	Psychologist	Female	37	7
23	Psychologist	Female	41	1
24	Psychologist	Female	32	7
25	Psychologist	Male	42	12
26	Psychologist	Female	63	11

previous job or elsewhere. This view was often accompanied by acknowledgement that there are differences among cancer survivors in their views of work and their motivation to resume working:

> *"Some people leave everything and assume the role of a sick person the minute they realize they are ill; others feel that continuing to work is very important. They do everything and arrange everything around work" (21).*

Professionals often associated perceived motivation to RTW with the meaning of work as present in cancer survivors prior to the onset of the illness. Cancer survivors who previously attributed importance to their work were more inclined to RTW compared with those, who in general, did not particularly like their jobs and showed low motivation to RTW. One oncologist said:

> *"People who felt that work was important before they got ill also felt it (RTW) was extremely important during and after the illness. Other people, who do not enjoy work, feel that work is not very important for them, that it is not part of their self-image; in these cases, the illness can be an excuse to leave, change jobs or stop working completely…" (6).*

Some professionals also expressed the view that motivation to RTW is associated with certain cancer types: "They feel that if they take hormone-based medicine, then they are ill...My impression is that it is somehow related to breast cancer" (11).

4.1.2 | Understanding cancer implications and its influence on RTW

Some cancer survivors were described as understanding that their health condition had implications on their work ability, even if they are not aware of the specific symptoms that may impair work. However, professionals also expressed the view that cancer survivors do not always understand illness implications—either because they exaggerate or underestimate implications and difficulties involved in RTW. Descriptions of cancer survivors who exaggerate illness implications were sometimes based on the belief that cancer survivors misunderstand side effects of treatment or health care instructions: "There are all kinds of side effects and delayed reactions; of course, they don't know that it is all normal and natural, and that everything is stimulated by stress and fear" (18). By contrast, other cancer survivors are viewed as downplaying illness implications or overestimating their own abilities: "Some people say 'no, I will continue to work as usual'" (13). While the level of understanding of cancer implications might be associated with variables such as survivors' educational level and health literacy, the results suggest that professionals view it as being more related to psychological processes (eg, denial) than to cognitive inability.

4.2 | A typology of professionals' view of cancer survivors

These 2 dimensions, *perceived motivation to work* and *understanding illness implications*, imply the following 4 groups of cancer survivors in the RTW context, as viewed by health professionals (example of quotes representing each group are presented in Table 2):

4.2.1 | Realists

This group consists of cancer survivors who are viewed as wanting to RTW as well as being aware of the implications of cancer and how they affect their ability to work. The perceived attitudes of these cancer survivors are congruent with professionals' own view of the cancer survivor's RTW.

4.2.2 | Enthusiasts

Professionals view cancer survivors in this group as being keen to RTW and determined to do so, as soon as possible and even before. Cancer survivors in this group are often viewed as being motivated because work is central to their identity and life, but also due to financial considerations. At the same time, professionals perceive these cancer survivors as lacking a thorough understanding of the possible implications of cancer on their RTW and work ability, often downplaying them or believing they can cope with the difficulties.

4.2.3 | Switchers

Cancer survivors in this group are viewed as "using" cancer as a means to stop working or change jobs, while fully understanding illness implications. Some professionals believe cancer survivors use cancer as a turning point, enabling them to not go back to a job they did not like in the first place or which was not paying well or as an opportunity to change jobs. In such cases, the illness is perceived as a turning point that engenders reconsideration of the priorities in the cancer survivors' lives.

4.2.4 | Worriers

Cancer survivors in this group are viewed as exaggerating illness implications and the limitations they put on RTW. Professionals view them as being fearful of their symptoms or the environment's reactions and as not believing in their ability to cope well with RTW.

4.3 | Professionals' perception of their role in RTW

Professionals generally maintain that their role is to assist cancer survivors to make the decision regarding RTW that will be the most beneficial to them. However, there were differences in the type of professional input described by social workers and psychologists compared with the clinical professions (ie, occupational physicians, oncologists, oncology nurses).

4.4 | Discussing options and implications

Social workers and psychologists often described their role as exploring, together with the cancer survivor, various options regarding RTW. A major part of exploring these issues is discussing the meaning of work and RTW for the cancer survivor. A psychologist said: "My role is to explore the subjective meaning that the patient attributes to work …for some people, it is an important part of their identity…others need it for the framework" (22). This issue is also related to the need to explore the meaning of work within the larger perspective of the cancer survivor's life: "Some ask more comprehensive questions about life—'What do I want now?'... In these cases, I assist in examining, questioning, contemplating and establishing goals" (26). Some of the professionals expressed the belief that a cancer survivor might not be aware that there are multiple possibilities; they might be "hooked" on 1 option, and it is part of the professional's role to present additional options. A social worker said: "Some patients say 'I will work as usual'. So, [my role] would be to induce spaces or pauses into these axioms, to say 'Look, it depends... everyone responds differently to these treatments', to give him more options" (13).

4.5 | Providing information and suggestions

Professionals, mainly physicians and nurses, attribute importance to providing cancer survivors with information to assist them in making RTW-related decisions. An occupational physician said:

> *"…just because there is maybe an additional risk in RTW doesn't mean one shouldn't do it. If the benefit is greater than the risk, it is important to give the person this information, so he can make the decision that will be best for him" (5).*

As part of their perceived role to provide information and make suggestions, some professionals provide specific recommendations

TABLE 2 A typology of professionals' perceptions of cancer survivors in the RTW context

Perceived Motivation			
		Want to return to work	**Do not want to return to work**
Understanding of cancer-work implications	Accurate	Realists "Work was his life. He went back to work, but worked very differently than how he had worked before, so we are constantly monitoring how to maintain boundaries" (22).	Switchers "Regarding people who work in more difficult jobs or jobs they did not like in the first place, my impression is that they do not go back to work" (8).
	Inaccurate	Enthusiasts "She looked terrible, but for her this [RTW] was the most important thing. She kept working like this until she could not work anymore and was hospitalized" (21).	Worriers "It is usually more of a psychological problem ...There is a difficulty to believe that they are really cured..." (8).

regarding the extent of work: "I tell them that during treatment it might be difficult to work, and I usually suggest reducing the work load during treatments" (7). This approach is also reflected in providing advice on how to manage symptoms in order to facilitate RTW. One nurse said: "As for side effects, we ask them to tell us how they feel and try to help them reduce side effects as much as possible" (21).

Professionals participating in the present study generally expressed the opinion that RTW is beneficial for cancer survivors: "Work is part of healing and it is also part of rehabilitation. You are not completely rehabilitated until you work" (6). Accordingly, some professionals believe that their role is to discuss the benefits of RTW, using arguments suggesting that work is good for recovery and psychological strength, and provides a diversion from the illness: "It is important to explain to them that one should go on living, coping, and functioning, and try to function as usual" (11).

While there is no one-to-one correspondence in regard to professionals' views of a cancer survivor type and their perceptions of their own role, there is some congruence. For example, with enthusiasts or anxious cancer survivors, who do not have a clear understanding of illness implications, professionals view their role as providing specific types of information by either reassuring (the anxious cancer survivors) or restricting (the enthusiastic cancer survivors).

5 | DISCUSSION

Cancer survivors encounter a variety of health care professionals who are involved in decision making regarding RTW—either directly (eg, occupational physicians) or indirectly (eg, oncologists).[15] While these professionals have different formal roles, their opinions regarding RTW might have a significant impact on cancer survivors' decision to RTW. The results suggest that professionals make sense of the cancer survivors' motivation to RTW in terms of "pulling" and "pushing" factors, in regard to both work and unemployment. For example, liking one's job pulls cancer survivors to RTW, while not wanting to relate to only the sick identity is viewed as pushing them away from non-employment. Many of the explanations and views presented by health professionals about factors that attract survivors to work and away from unemployment are similar to previous findings regarding cancer survivors' personal views about RTW.[7,16,34] For example, in a study of attitudes toward work among breast cancer survivors,[35] work disability was experienced as either a disruption involving loss, an unpleasant episode, or a meaningful period providing the opportunity to reconsider priorities. Our findings suggest that health professionals recognize the major emotions and motivations that guide cancer survivors' disposition toward RTW.

A second salient dimension for professionals is the cancer survivor's understanding of illness implications regarding work. Professionals' view of cancer survivors is aligned with the notion[4] that—compared with their actual functional limitations, in cancer survivors there may be a lack of congruence between their expectations and their actual ability to work. That is, some cancer survivors may perceive their limitations as more significant than they are in reality, while others may think they can work harder than they actually can. Previous research implies that more information regarding illness implications (eg, treatment side effects) is needed for cancer survivors with lower health literacy (ie, the capacity to obtain, process, and understand health information), eg,[36] and lower education level.[37]

These 2 dimensions—motivation and understanding implications—generate a typology of various cancer survivor types as perceived by professionals. Based on previous research regarding professionals' perceptions relating to cancer survivors' characteristics, it is likely that after receiving even a small amount of information from the cancer survivors, professionals tend to categorize them into one of these groups.[22,23] This is important because such perceptions often unintentionally affect subsequent behavior, which is to a certain extent based on the professional's view of his or her role.[22-25]

Previous research[38] found that physicians provide information designed to promote realistic expectations of altered performance following illness and treatment. The results of the present study support these findings by showing that physicians and nurses perceive their role as providing information to enhance cancer survivors' understanding of the implications of the illness, and/or making concrete suggestions regarding RTW. The results further highlight the differences between physicians and nurses and social workers and psychologists, who view their role as discussing various options with the cancer survivor, positioning RTW within the cancer survivor's hierarchy of preferences, and highlighting options that were not familiar to the cancer survivor.

5.1 | Clinical implications

A major implication of the study is that the training of professionals should increase awareness of the assumptions they make about cancer survivors in regard to RTW, and the impact of these assumptions on their behavior. This type of awareness might enhance professionals' sensitivity and caution in their interaction with cancer survivors. The results indicate that some health professionals adapt communication to their perception of the cancer survivors' understanding of illness implications; yet, more structured training in this regard might further facilitate the interaction with cancer survivors who tend to exaggerate or downplay illness implications. Additionally, awareness of role-perceptions might elaborate professionals' views of their role. For example, physicians and nurses might be trained to engage in an open discussion with cancer survivors, acknowledging various options and engaging in a shared decision-making process. Due to the similarity in the systems of care for cancer survivors in Israel, the US and Western Europe, especially regarding the high rates of survivorship as well as the interdisciplinary framework of care for cancer survivors, the implications of the present findings could be transferrable to interdisciplinary oncology professionals worldwide.

5.2 | Strengths, limitations and future research

Collecting data from a variety of health professionals representing both physical and mental treatment provides a comprehensive understanding of professionals' perspectives. In terms of limitations, we do not have enough professionals in each occupational group to allow for the comparison and identification of differences. Such comparisons might reveal differences associated with the professional's extent of

formal involvement in RTW. For example, occupational physicians might have more diverse views of cancer survivors' motivation and understanding than oncologists because the formers' interaction with cancer survivors is related directly to RTW issues. Future research should examine the differences among health professions in relation to the variables found to be significant in this study. In addition, the results might be affected by self-selection bias. For example, health professionals who support RTW might have been more inclined to participate in this study than professionals who do not believe RTW is beneficial to cancer survivors. Conducting telephone interviews enabled us to include participants whose schedule was very busy but might also have resulted in missing some information which could have been obtained in face-to-face, longer, and more intimate interviews. Based on professionals' evaluation that some survivors do not have a sufficient understanding of the implications of cancer regarding RTW, it is desirable to explore the impact of education and health literacy in the RTW context. In addition, future research would do well to explore the impact of professionals' perceptions and beliefs on the dynamics of cancer survivor-professional interaction.

ACKNOWLEDGEMENTS

The study was funded by the Israel National Institute of Health Policy and Health Services Research (No. 2016/15).

ORCID

Dana Yagil http://orcid.org/0000-0002-1745-9593

REFERENCES

1. McGrath PD, Hartigan B, Holewa H, Skarparis M. Returning to work after treatment for haematological cancer: findings from Australia. *Support Care Cancer*. 2012;20(9):1957-1964.
2. Tiedtke C, de Rijk A, Dierckx de Casterlé B, Christiaens MR, Donceel P. Experiences and concerns about 'returning to work' for women breast cancer survivors: a literature review. *Psycho-Oncology*. 2010;19(7):677-683.
3. Calvio L, Peugeot M, Bruns GL, Todd BL, Feuerstein M. Measures of cognitive function and work in occupationally active breast cancer survivors. *J Occup Environ Med*. 2010;52(2):219-227.
4. Pryce JMF, Haslam C. Cancer survivorship and work: symptoms, supervisor response, co-worker disclosure and work adjustment. *J Occup Rehabil*. 2007;17(1):83-92.
5. Spelten ER, Sprangers MA, Verbeek JH. Factors reported to influence the return to work of cancer survivors: a literature review. *Psycho-Oncology*. 2002;11(2):124-131.
6. Steiner JF, Nowels CT, Main DS. Returning to work after cancer: quantitative studies and prototypical narratives. *Psycho-Oncology*. 2010;19(2):115-124.
7. Nilsson MI, Olsson M, Wennman-Larsen A, Petersson LM, Alexanderson K. Women's reflections and actions regarding working after breast cancer surgery—a focus group study. *Psycho-Oncology*. 2013;22(7):1639-1644.
8. Wells M, Williams B, Firnigl D, et al. Supporting 'work-related goals' rather than 'return to work' after cancer? A systematic review and meta-synthesis of 25 qualitative studies. *Psycho-Oncology*. 2013;22(6):1208-1219.
9. Amir Z, Neary D, Luker K. Cancer survivors' views of work 3 years post diagnosis: a UK perspective. *Eur J Oncol Nurs*. 2008;12(3):190-197.
10. Blinder VS, Murphy MM, Vahdat LT, et al. Employment after a breast cancer diagnosis: a qualitative study of ethnically diverse urban women. *J Community Health*. 2012;37(4):763-772.
11. McKay G, Knott V, Delfabbro P. Return to work and cancer: the Australian experience. *J Occup Rehabil*. 2013;23(1):93-105.
12. Engel J, Kerr J, Schlesinger-Raab A, Eckel R, Sauer H, Hölzel D. Predictors of quality of life of breast cancer patients. *Acta Oncol*. 2003;42(7):710-718.
13. Yarker J, Munir F, Bains M, Kalawsky K, Haslam C. The role of communication and support in return to work following cancer-related absence. *Psycho-Oncology*. 2010;19:1078-1085.
14. Tiedtke C, Donceel P, Knops L, Désiron H, De Casterlé BD, de Rijk A. Supporting return-to-work in the face of legislation: stakeholders' experiences with return-to-work after breast cancer in Belgium. *J Occup Rehabil*. 2012;22(2):241-251.
15. Caron M, Durand MJ, Tremblay D. Perceptions of breast cancer survivors on the supporting practices of their supervisors in the return-to-work process: a qualitative descriptive study. *J Occup Rehabil*. 2017;1-8. https://doi.org/10.1007/s10926-017-9698-x
16. Dewa CS, Trojanowski L, Tamminga SJ, Ringash J, McQuestion M, Hoch JS. Work-related experiences of head and neck cancer survivors: an exploratory and descriptive qualitative study. *Disabil Rehabil*. 2017;1-7. https://doi.org/10.1080/09638288.2017.1291764
17. Tan FL, Loh SY, Su T, Veloo VW, Ng LL. Return to work in multi-ethnic breast cancer survivors—a qualitative inquiry. *Asian Pac J Cancer*. 2012;13(11):5791-5797.
18. Bondesson T, Petersson LM, Wennman-Larsen A, Alexanderson K, Kjeldgård L, Nilsson MI. A study to examine the influence of health professionals' advice and support on work capacity and sick leave after breast cancer surgery. *Support Care Cancer*. 2016;24(10):4141-4148.
19. Nilsson M, Olsson M, Wennman-Larsen A, Petersson LM, Alexanderson K. Return to work after breast cancer: women's experiences of encounters with different stakeholders. *Eur J Oncol Nurs*. 2011;15(3):267-274.
20. Tamminga SJ, De Boer AG, Verbeek JH, Frings-Dresen MH. Breast cancer survivors' views of factors that influence the return-to-work process—a qualitative study. *Scand J Work Environ Health*. 2012;38(2):144-154.
21. O'Malley MS, Earp JA, Hawley ST, Schell MJ, Mathews HF, Mitchell J. The association of race/ethnicity, socioeconomic status, and physician recommendation for mammography: who gets the message about breast cancer screening? *Am J Public Health*. 2001;91(1):49-54.
22. Sikorski C, Luppa M, Glaesmer H, Brähler E, König HH, Riedel-Heller SG. Attitudes of health care professionals towards female obese patients. *Obes Facts*. 2013;6(6):512-522.
23. Teixeira FV, Pais-Ribeiro JL, Maia A. A qualitative study of GPs' views towards obesity: are they fighting or giving up? *Public Health*. 2015;129(3):218-225.
24. Fallin-Bennett K. Implicit bias against sexual minorities in medicine: cycles of professional influence and the role of the hidden curriculum. *Acad Med*. 2015;90(5):549-552.
25. Girvan EJ, Deason G, Borgida E. The generalizability of gender bias: testing the effects of contextual, explicit, and implicit sexism on labor arbitration decisions. *Law Hum Behav*. 2015;39:525.
26. van Muijen P, Duijts SF, van der Beek AJ, Anema JR. Prognostic factors of work disability in sick-listed cancer survivors. *J Cancer Surviv*. 2013;7(4):582-591.
27. Borras JM, Albreht T, Audisio R, et al. Policy statement on multidisciplinary cancer care. *Eur J Cancer*. 2014;50(3):475-480.
28. JC1 H, Andersen B, Breitbart WS, et al. Distress management. *Natl Compr Canc Netw*. 2013;11:190-209.
29. McLeod J. *Introduction: Critical Issues in the Methodology of Qualitative Research*. Sage; 2001.
30. Morse JM. *Critical Issues in Qualitative Research Methods*. Sage; 1994.

31. D'Cruz H, Gillingham P, Melendez S. Reflexivity, its meanings and relevance for social work: a critical review of the literature. *Br J Soc Work*. 2007;37:73-90.
32. Glaser BG, Strauss AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine de Gruyter; 1967.
33. Strauss A, Corbin J. *Basics of Qualitative Research Techniques*. Sage; 1998.
34. Petersson LM, Nilsson MI, Alexanderson K, Olsson M, Wennman-Larsen A. How do women value work shortly after breast cancer surgery and are their valuations associated with being on sick leave? *J Occup Rehabil*. 2013;23(3):391-399.
35. Tiedtke C, de Casterlé BD, de Rijk A, Christiaens MR, Donceel P. Breast cancer treatment and work disability: patient perspectives. *Breast J*. 2011;20:534-538.
36. Schmidt A, Ernstmann N, Wesselmann S, Pfaff H, Wirtz M, Kowalski C. After initial treatment for primary breast cancer: information needs, health literacy, and the role of health care workers. *Support Care Cancer*. 2016;24(2):563-571.
37. Martin MY, Evans MB, Kratt P, et al. Meeting the information needs of lower income cancer survivors: results of a randomized control trial evaluating the American cancer society's "I Can Cope". *J Health Commun*. 2014;19(4):441-459.
38. Morrison T, Thomas R, Guitard P. Physicians' perspectives on cancer survivors' work integration issues. *Can Fam Physician*. 2015;61:e36-e42.

How to cite this article: Yagil D, Eshed-Lavi N, Carel R, Cohen M. Health care professionals' perspective on return to work in cancer survivors. *Psycho-Oncology*. 2018;27:1206–1212. https://doi.org/10.1002/pon.4649