Can Returning to Work Have Therapeutic Benefits for Cancer Survivors?

By Stephen Bevan

A year ago, getting back to work was the last thing on my mind. I had just finished the first of two rounds of chemotherapy for oesophageal cancer and had spent New Year's Eve in hospital having had my second A&E admission that month following an infection. Whether I had set my 'out of office' message or not, or whether I was going to make the next staff meeting in the office was, frankly, of no consequence. My focus was getting over my infection and restoring my stamina in time for the surgery I was due to have in February. One year on, and my treatment finished, I've made it back to work and my focus is firmly on the future and not so much on the past.

Yet, in my role as Ambassador for Working With Cancer, I can't help reflecting on the conversations and events which helped decisively both with my recovery and my eventual return to my job. As we now know, around half of people diagnosed with cancer are of working age. This, together with improved survival rates, means that employees (or, indeed, the self-employed) who want or need to continue working after a diagnosis will be more common in workplaces of the future. Yet achieving and sustaining successful return to work (RTW) is much harder than it ought to be. Incredibly, fewer than two-thirds of employees with cancer have returned to work or are still working a year after getting a diagnosis.

Clearly one important factor here is the willingness of employers to support employees at diagnosis, during treatment and once treatment is over. While awareness in the business sector is improving – and credit here goes to Working With Cancer and others whose work focuses on this – it also struck me that more could be done to help healthcare professionals (HCPs) have work-related conversations with cancer patients for whom an eventual return to work might be a psychological or financial necessity. I remember three conversations with HCPs during my treatment that emphasised the importance of the 'return to work' conversation.

The first was with a Consultant during the early stages of my treatment. His sensible advice was that there was no reason why I couldn't still work during chemotherapy but that my ability to do so would fluctuate as the drugs took effect. He said that he had other patients, including those who were engaged in heavy, physical work, who continued to work almost without a break during chemotherapy. He also said that my body would tell me what I was capable of and that I should make sure I didn't over-stretch myself. This all made perfect sense to me but I was struck that, given that this was our third meeting, it had still taken me to raise the issue of work in the first place. Of course, getting me on the right course of treatment has to have top clinical priority at times like that, but I've heard from patients in other fields (rheumatology, neurology and cardiology, for example) that RTW conversations are only rarely initiated by HCPs.

The second conversation was with a wonderful therapeutic radiographer who looked after me during my radiotherapy. Her job was to check on my progress each week and to provide me with support if I needed it. One of our meetings was dominated by the 'return to work' conversation. Again, I had initiated it and the interesting part was that I spent most of the session talking about the principles of vocational rehabilitation (VR is a professional interest of mine, of course). It was a great conversation but I was struck by her admission that VR was almost never a subject for discussion in multidisciplinary team (MDT) meetings and that it was not given any 'airtime' during her own clinical training. She hoped that things had improved since then.

The third conversation gave me a chance to test out her hope because, during my second set of chemotherapy treatments, a group of nervous-looking first year medical students paid a visit to the cancer 'suite' and their tutor asked me if I'd be happy to talk to four of them about my treatment and my wider experience of cancer care to date. In the course of this exchange I asked them whether they thought that helping cancer patients to stay in work both during and after their treatment might have therapeutic benefits. They clearly thought that this question was a little 'left field' and admitted that, so far, nothing they had been taught had even remotely touched on either mental health comorbidity nor on the physical or psychological benefits of work to some patients. Again, I wasn't entirely surprised to get this response, but it did make me wonder how much priority the idea might have among HCPs that work could be a 'clinical outcome' of care for patients of working age.

There are many reasons why RTW rates among cancer survivors may be poor across Europe, despite the advances in cancer treatment, and many of these fall within the scope of employers. However, the fact that RTW still seems to feature so rarely in the conversations patients have with HCPs must also be playing a part. Of course many HCPs (especially GPs) see their role as being the 'patient's advocate' and this means that they are reluctant to risk encouraging patients to return to intense or even toxic workplaces if they think that their health will be put at risk. But we know from several studies that patients tend to follow a doctors' RTW advice very precisely and this is, of course, a good thing as long as the advice is sound and informed by the evidence base. Although my own experience of RTW conversations was quite patchy, I had the advantage of having a little more knowledge on the topic than average. My worry is that, unless we can 'mainstream' the idea among HCPs that work – especially good work - can have therapeutic benefits, then the advice which cancer patients get on the topic will remain something of a lottery.