

Physicians' perspectives on cancer survivors' work integration issues

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Abstract

Objective To explore physicians' perspectives on supporting cancer survivors' work integration (WI) issues.

Design Using vignette methodology, 10 physicians were individually interviewed. Interviews were audiorecorded, transcribed, and subsequently analyzed.

Setting Ontario.

Participants A total of 10 physicians participated: 5 oncologists and 5 FPs.

Methods An inductive interpretive description approach was used to identify themes across the entire data set.

Main findings Physicians primarily focused on patients' medical needs and did not spontaneously address WI issues with them. Instead, it was their patients who raised WI issues, most often owing to insurance requirements. Physicians readily completed insurance forms to aid patients' well-being, but they did not believe their guidance was empirically sound based upon their limited WI training; rather, they recognized other health professionals, such as occupational therapists, as being better equipped to address cancer survivors' WI issues. Despite this recognition, referrals for WI support were not routinely facilitated owing to a lack of resources or knowledge.

Conclusion Owing to a lack of training and time, as well as the belief that WI issues are not part of their mandate of care, physicians perceive themselves as ill-equipped to address cancer survivors' WI issues. These findings underscore the need for enhanced awareness of cancer survivors' WI issues and the need for accessible support services offered by duly trained health care professionals, such as occupational therapists, ideally working in a multidisciplinary team to holistically address cancer survivors' unique needs.

EDITOR'S KEY POINTS

- This study found that physicians did not consider work integration (WI) issues to be part of their training or their mandate of care.
- Physicians believed that they were ill-equipped to address WI issues; they pointed to occupational therapists as a superior option for providing WI support.
- Although physicians recognized other health care professionals as ideal for providing WI guidance to cancer survivors, they rarely made referrals; this might in part be owing to the perception among physicians that patients viewed work as a burden. Undergraduate or residency training in this regard, potentially involving cancer survivors as educators, might sensitize physicians to the variable importance work holds for cancer survivors.

This article has been peer reviewed.
Can Fam Physician 2015;61:e36-42

L'opinion des médecins sur la réinsertion au travail des survivants du cancer

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Résumé

Objectif Vérifier comment réagissent les médecins à l'idée de conseiller les survivants du cancer sur la question de la réinsertion au travail (RT).

Type d'étude À l'aide de courtes histoires (vignettes), 10 médecins ont été interviewés individuellement. Ces interviews ont été enregistrées et transcrites, pour ensuite être analysées.

Contexte L'Ontario.

Participants Dix médecins ont participé : 5 oncologistes et 5 MF.

Méthodes Une description interprétative inductive a servi à identifier les thèmes pour l'ensemble des données.

Principales observations Les médecins étaient principalement attentifs aux problèmes médicaux des patients et ne discutaient pas spontanément des questions de RT avec eux. Ce sont plutôt leurs patients qui soulevaient cette question, le plus souvent en raison d'exigences de la part des assurances. Les médecins acceptaient volontiers de remplir les formulaires d'assurance pour favoriser le bien-être des patients, mais ils ne croyaient pas que leurs conseils étaient nécessairement adéquats vu leur peu de formation sur le sujet de la RT; ils considéraient plutôt que d'autres professionnels de la santé, par exemple les ergothérapeutes, étaient mieux préparés pour s'occuper de la question du RT des survivants du cancer. Malgré cela, ils ne dirigeaient pas les patients en consultation de façon routinière, en raison d'un manque de ressources ou de connaissances.

POINTS DE REPÈRE DU RÉDACTEUR

- Cette étude a montré que les médecins considèrent que la question de la réinsertion au travail (RT) ne fait pas partie de leur formation ni des soins qu'ils doivent prodiguer.
- Les médecins se disaient mal préparés pour s'occuper de la question de la RT; ils croyaient plutôt qu'un ergothérapeute est un meilleur choix pour offrir ce genre de service.
- Même s'ils jugeaient que d'autres professionnels de la santé sont mieux placés pour aider les survivants du cancer à retourner au travail, les médecins dirigeaient rarement ces patients vers ces professionnels; cela pourrait être dû en partie au fait qu'ils croient que les patients considèrent le travail comme un fardeau. À cet égard, une formation au niveau du premier cycle ou de la résidence, possiblement avec la collaboration de survivants du cancer comme moniteurs, pourrait sensibiliser les médecins à l'importance variable que les survivants du cancer attachent au travail.

Conclusion Parce qu'ils n'ont ni la formation ni le temps nécessaires, et parce qu'ils croient que la RT ne fait pas partie de leur mandat, les médecins estiment qu'ils ne sont pas bien préparés pour en discuter avec les survivants du cancer. Ces résultats montrent la nécessité d'être mieux renseignés sur la question de la RT des survivants du cancer et sur les services que peuvent offrir des professionnels de la santé compétents comme les ergothérapeutes, travaillant idéalement au sein d'une équipe multidisciplinaire, pour répondre de façon holistique aux besoins particuliers des survivants du cancer.

Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2015;60:e36-42

The ability to work directly influences quality of life (QOL) for many cancer survivors. Work might represent a return to normalcy, offer social support or financial benefits, and be related to other QOL implications.¹ Predictive factors for return to work (RTW) include the nature of the work, type and stage of cancer, required treatment, and social factors (eg, sex, age, education, income).² Therefore, not all cancer patients are able to RTW. In fact, a 37% higher risk of unemployment is found among cancer patients.³ With increasing survivorship rates, enhanced and earlier diagnosis, aging of the working population, and the fact that people are working longer before retirement, facilitating cancer survivors' work integration (WI) is a pressing matter. Work integration considers not only the functional ability of RTW but also the ability to continue working during and after treatment.

Physicians are the health professionals most involved with cancer patients, from initial investigation to follow-up care. Disability insurers routinely request physicians' guidance for understanding cancer survivors' work abilities. Despite this, many survivors report having to negotiate RTW without physician advice.^{4,5} It has been suggested that some cancer patients are off work unnecessarily, and a Japanese study suggested that more patients would be able to work through treatment and achieve earlier and more successful WI if physicians were more aware of cancer patients' working realities.^{6,7} European studies describe the role of occupational physicians in cancer survivors' WI support, but such specialists are less abundant in Canada.⁸⁻¹⁰ Although Canadian FPs are well positioned to provide occupational health support, they would benefit from additional training.¹¹

A multiphase study is under way to bridge the gap in WI support for cancer survivors. The goal of this article was to explore physicians' perspectives on supporting cancer survivors' WI issues.

METHODS

Recruitment

A mixed recruitment method was used to target information-rich sources. An invitation to participate was sent to an oncology team at one large oncology centre. Interested oncologists provided their e-mail addresses on a sign-up sheet. The researcher (T.M.) contacted each oncologist individually. Recruitment of FPs required several methods. An invitation to participate was widely disseminated (eg, to a hospital family medicine clinic; in an FP newsletter; to personal contacts; through the snowball technique; and at an international research conference).

Participants

All participants were English-speaking physicians with an active clinical role with cancer survivors. Ten

participants, 5 oncologists and 5 FPs, was adequate for clinically relevant themes to emerge across the group.¹² The oncologists all practised in one large urban teaching hospital in Ottawa, Ont, which focused on providing treatment for breast, gastrointestinal, and skin cancer, sarcoma, and melanoma. The average age of the 2 female and 3 male oncologists was 48.4 years (range 39 to 59 years), with a range of practice experience between 3 weeks and 30 years. The 5 male FPs were between 41 and 59 years of age, with an average of 21.6 years of practice (range 6 to 34 years). Family physicians practised in Ontario, Newfoundland, Manitoba, Minnesota, and North Carolina.

Procedure

Following confirmation of a physician's participation in the study, arrangements were made for an in-person interview to occur at a time and location of convenience (eg, physician office, available conference room). A consent form was reviewed in detail and signed by each participant before the interview. Individual qualitative interviews were conducted using vignette methodology. Vignettes are short stories that focus on specific topics; they are designed to explore participants' perceptions, beliefs, and attitudes on the topic via open, yet focused, discussions.¹³⁻¹⁵ The content and delivery method (eg, written text, passage read aloud, video) of vignettes vary, but the common element is the presentation of a situation to be explored through dialogue. Creation of a safe distance is intended by the situational discussion of the vignette, encouraging participants' open discursive exchange.¹⁴ Vignettes can be generated from a range of sources, including previous research findings, as was the case in this study.¹³ Participants were asked what they or a third party would or should do given the context, with an opportunity to segue into personal experiences.¹³ Seven vignettes were developed from themes that emerged from a previous inquiry with cancer survivors¹ (eg, social connections at work, importance of work-life balance, required accommodations) and were important for this current study. Each vignette comprised a photograph with an accompanying narrative depicting an important aspect of a cancer survivors' WI experience. The images and words in these vignettes contextualize each other, forming different representations than either can accomplish independent of the other.¹⁶ **Figure 1** presents an example of a vignette. The vignettes were presented in hard-copy format to participants. The vignettes and interview protocol were pilot-tested with a physician volunteer before initiating recruitment. The semistructured interviews, each approximately 1 hour, were audiorecorded and transcribed.¹² The study methods were approved by both the University of Ottawa and the Ottawa Health Science Network research ethics boards.

Figure 1. Vignette example: Social connectedness.

Although Lisa's employer invested in equipment to allow her to work from home during her various cancer treatments, Lisa attended the office several times per week for half-days as her appointments and tolerance permitted. For Lisa, the sense of being connected to others at work was of utmost importance.



It's my coffee cup. I realized maybe about a month and a half ago that one of my friends was still making the full pot, expecting me to come in at any time. There was always a full pot of coffee on. He was making the coffee just in case I came in. So how nice is that?

Data analysis

Interpretive description was used to analyze the interview transcripts. This qualitative research approach provides a way of naming and referencing well-founded logic derived in clinical domains, specifically health. Interpretive description is best used when there is a practice goal and the analysis is grounded in what is known and not known empirically about a phenomenon.¹² The inductive analysis of the data was aided by NVivo, version 10, qualitative data analysis software.¹⁷ Verbatim transcripts were read and reread, initially holistically and then for interesting data, which were coded into inductively developed broad groupings. Segments of data were applied to multiple groups if relevant. The analysis was predominantly undertaken by the first author (T.M.), who was also the interviewer. A deep immersion in the whole data set informed the active process of looking for patterns and then relationships within the data from collection onward. A preliminary analysis was reviewed by the second author (R.T.) who examined both the analysis process and the findings, and provided additional input. The review was facilitated by use of an audit trail maintained throughout the coding process. The thematic summary of key findings, supported by participant quotes, provides an

accessible insight into physicians' perspectives on cancer survivors' WI issues.¹²

FINDINGS

Three themes emerged from the physician interviews: the challenge of considering and providing advice for matters beyond expertise; the burden of insurance gate-keeping; and the tension between medical advice and guidance for living.

Challenge of considering and providing advice for matters beyond expertise. Physicians focus on patients' medical needs. As a result of the potentially life-threatening matters related to cancer, little consideration is given to patients' work.

You're talking about cancer, death, dying, misery, chemotherapy to avoid death ... [work is] just so trivial when you're talking about really bad things. (Onc1)

Physicians believe the gravity of cancer overshadows the importance of work for patients. "If you're on chemotherapy, you're not interested in hearing about RTW." (Onc2)

Physicians support patients who continue to work during treatment as long as there is no medical risk. "If there's a medical reason not to do something, I'll tell you." (Onc2) But when oncologists were asked about what their preferences were for patients undergoing treatment, they overwhelmingly supported the notion that patients take a period of time off work to assess the effects of treatment, to rest, and to address psychosocial adjustment. Family physicians tend to defer to oncologists' advice during active treatment.

Physicians provide general WI guidance to patients and insurers when they are specifically asked to do so. However, several oncologists expressed that their opinions on WI were neither well founded on training nor necessarily reliable.

This isn't something that we get taught in medical school or fellowship. (Onc5)

I think we try our best, but I don't know if we do it that well. (Onc4)

In addition, they also stated that the nature of the information that insurers requested was not within physicians' mandate of care and could in fact negatively affect WI.

Have I assessed how many pounds she can lift, for how many minutes, of course I'm not going to do that I don't know and I don't really care. In fact, if I see

that, I'm probably even more likely [to say] that she can't go back to work. (Onc1)

Several physicians identified more suitably trained professionals: "I'm not the occupational therapist. There are much smarter people who can do that sort of thing." (Onc1)

Despite recognizing that WI issues are better addressed by others, oncologists and FPs almost never refer patients for WI support. However, physicians do refer cancer patients to social workers, psychologists, or psychiatrists for psychosocial, emotional, cognitive, and financial counseling. For physical issues, patients are referred to physiotherapists. Even when WI issues are identified, physicians maintain these same referral patterns. "I think maybe social work would be appropriate It's my go-to. I guess I never even think of OT [occupational therapy outside of] the inpatient setting." (Onc5)

Notably, both American participants (FP4, FP5) identified occupational therapists as being a key referral for work and home environment issues for cancer patients; however, none of the Canadian physicians considered such referrals. "I have never referred my patient to OT [occupational therapy]. They'll often see a physiotherapist for other reasons like lymphedema." (Onc3)

Reasons for not referring include questions about availability.

We have occupational therapy available, but I do not think that it's covered through Manitoba Health. I'm not positive, but I don't think so. (FP3)

Occupational therapists, to my knowledge, are not directly covered through OHIP [Ontario Health Insurance Program], but there might be some facilities through the cancer clinic. (FP2)

How do we do this? Do we need a program for everyone to go through? Or should we have a program where we send people who need that kind of program? (Onc4)

A collaborative team approach was identified as ideal:

They should have an occupational therapist assess their ability to work. A step-by-step process ... to see what could be done to accommodate them, and then have those recommendations put forth to the employer That would be ideal, and then from a medical standpoint, if there are medications that were required to manage pain or nausea, or something like that, then that would be my role. (FP2)

Although physicians feel challenged when asked for advice on WI issues, they do not routinely refer patients

to other health care providers for WI issues owing to a lack of resources or because it does not occur to them.

Burden of insurance gatekeeping. Physicians do not spontaneously discuss WI; rather, this topic is initiated by patients. "If this was something that was important to the patient, they would bring it up." (FP1)

Most often, the impetus behind patients raising the topic is insurance benefits. "The [insurance] form is given a front and centre seat" (Onc3) during a meeting at which the patient intends to raise the issue.

These forms present challenges. One physician complained about the large volume of insurance forms. "They are going to be the death of medicine. It's gotten ridiculous." (FP2)

Several physicians indicated that the generic forms lack applicability to a cancer context. "They're very general insurance forms. The insurance company needs to understand [cancer is] a different entity and the questions they ask may need to be a bit different." (Onc4)

While different approaches are used (eg, asking patients to write suggested responses), all physicians complete the forms as part of routine care. "I always sign the form. It's less contentious and less hurtful than not to." (Onc3)

However, the insurance forms can trigger tension in the physician-patient relationship. "The physician is faced with this constant conflict of the bad guy go back to work, versus the good guy cure the cancer. It's a constant conflict with these forms." (Onc1)

Most often, patients address the topic of WI with their physicians when their insurance companies request medical opinions about their conditions. Physicians usually assume that WI is undesirable for patients.

Tension between medical advice and guidance for living. Aside from completing the insurance forms, physicians do not routinely provide unsolicited work-related advice. Oncologists attribute this to their focus being on treating cancer, and FPs believe that advising cancer survivors' on WI issues is not part of their mandate of care. "I don't think they see that as the task of their primary care physician ... as far as returning to work, I think they see that as coming from their oncologist." (FP3)

Thus, neither group appears to perceive WI advice to be part of their mandate. When specifically asked for WI guidance, physicians provide general information, including anticipated sequelae of treatment (eg, fatigue), universal precautions related to impaired immunity, and realistic expectations of altered performance. Flexibility to accommodate these issues is critical. "Initially go back in a reduced role ... you may not be back at 100% ... advice to take things in stride, don't bite off too much, know your limitations." (Onc5)

However, the guidance provided often lacks practical application to patients' specific work duties and environment.

DISCUSSION

It is well established that cancer survivorship rates continue to rise, that RTW is an important QOL consideration for many cancer survivors, and that cancer survivors frequently report negotiating WI issues without advice from health professionals.^{1,4,5,18} It is also commonly realized that physicians have the most frequent contact with cancer survivors from investigation onward, and that insurance companies routinely request medical opinions about cancer survivors' work abilities.

This study found that although physicians completed insurance forms at the request of their patients, they did not consider WI issues to be part of their training or their mandate of care. This is despite the fact that the Canadian Medical Association outlines one of the treating physicians' roles as working with other health care professionals to facilitate patients' RTW.¹⁹ As in previous studies,²⁰ this study's participants believed that they were ill-equipped to address WI issues and identified other health care professionals as better suited to providing this support. An inherent issue might be unavailability of other health care professionals in cancer care who can address rehabilitation issues in general and WI issues specifically. Even if that is the case, these participant physicians rarely referred cancer survivors to other health professionals for WI support. This might in part be owing to the fact that most of this study's participants perceived work as a burden to patients. This perception is inconsistent with findings from cancer survivors.¹ Undergraduate or residency training for physicians in this regard, potentially involving cancer survivors as educators, might sensitize physicians to the variable importance work holds for cancer survivors.

This study's participants spontaneously pointed to occupational therapy as one remedy for facilitating cancer survivors' WI issues. Although neither the presented vignettes nor the interview protocol referred to occupational therapy, some participants became aware of the interviewer's professional training through polite introductory conversation. Occupational therapists focus on enabling engagement in meaningful occupations.²¹ To optimize engagement, occupational therapists consider the client's holistic abilities (ie, affective, cognitive, and physical), the requisite demands of the occupation, and the presenting environmental conditions (ie, physical, institutional, cultural, and societal).²¹ Considering the multifaceted functional implications of both cancer and its treatment, occupational therapists' scope of practice would appear to be an ideal fit.

Several participants pointed to the ideal situation of WI support being delivered by a multidisciplinary

team, as has been previously suggested in the literature.⁴ Based on the opinions of this study's participants, there are many possible permutations to this team. Beyond the occupational therapist, other team members might optimally include physicians to provide medical guidance, physiotherapists to manage physical limitations, psychologists or psychiatrists to address emotional health concerns, neuropsychologists to review cognitive issues, and a vocational counselor to provide career advice if the patient requires different employment. These foundational team members will work with other situation-specific members (including employer and insurer) to provide appropriate guidance. Ideally, a multidisciplinary team should be available to all cancer survivors without physician referral, from the point of diagnosis, to provide them with ready access to the various team members for their specific needs.⁴ The advent of such support programs would ensure patient WI issues were addressed without burdening busy physicians, but would first require physicians and medical institutions to become aware of cancer patients' working realities.⁷

A unique finding of this study points to the need to raise awareness among both employers and insurers about the specificity of cancer survivors' WI needs. There should be questionnaires that specifically consider those with chronic conditions, including cancer survivorship.²² While physicians' medical insights are imperative to effective planning, cancer survivors' holistic WI requirements might be better served outside of the biomedical approach currently taken by insurers' surveys.

Limitations and strengths

This modest inquiry, as part of a larger multistage study, necessarily limited the number of participants to 10. Thematic saturation might not have been attained. Further exploration of the topic is indicated. As with all qualitative studies, caution is required in interpreting the study findings. The findings are contextually bound to these participants' experiences and might differ both geographically owing to variable health regulations and by work milieus (eg, services offered, cancers treated). However, these participants, all interested in the topic of cancer survivors' WI issues, demonstrated a pattern of little clinical attention to the topic. One can only surmise that physicians without this interest are paying even less attention to survivors' WI issues. While the second author (R.T.) reviewed and refined the first author's (T.M.) work, there was only 1 researcher (T.M.) fully immersed in the data collection and analysis. A second coder or analyst might have yielded an altered data analysis.

Conclusion

Although physicians are relied upon for WI guidance, they should not have to provide advice on matters

beyond their areas of expertise. Undergraduate or residency training could raise physicians' awareness of WI issues. Although they rarely referred, some participants in this study pointed to occupational therapists, who currently provide care to survivors of conditions such as stroke and brain injury, as a superior option for providing WI support. An ideal remedy would be to make a multi-disciplinary survivorship support team accessible to all cancer survivors to address their idiosyncratic needs. ✨

Dr Morrison is a postdoctoral fellow, **Dr Thomas** is Full Professor and Canada Research Chair in Qualitative Health Research with Marginalized Populations, and **Dr Guitard** is Associate Professor, all at the School of Rehabilitation Sciences at the University of Ottawa in Ontario.

Contributors

Dr Morrison contributed to the concept and design of the study, data gathering, analysis, and interpretation. **Dr Thomas** contributed to the concept and design of the study, analysis, and interpretation. **Dr Guitard** contributed to the concept and design of the study. All authors contributed to preparing the manuscript for submission.

Competing interests

None declared

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References

1. Morrison TL, Thomas RL. Survivors' experiences of return to work following cancer: a photovoice study. *Can J Occup Ther* 2014;81(3):163-72.
2. Van Muijen P, Weevers NL, Snels IA, Duijts SF, Bruinvels DJ, Schellart AJ, et al. Predictors of return to work and employment in cancer survivors: a systematic review. *Eur J Cancer Care (Engl)* 2013;22(2):144-60. Epub 2012 Dec 26.
3. De Boer AG, Taskila T, Ojajärvi A, van Dijk FJ, Verbeek JH. Cancer survivors and unemployment: a meta-analysis and meta-regression. *JAMA* 2009;301(7):753-62.
4. Nitkin P, Parkinson M, Schultz IZ. *Cancer and work: a Canadian perspective*. Toronto, ON: Canadian Association of Psychosocial Oncology; 2011. Available from: www.capo.ca/pdf/CancerandWork-ACanadianPerspective.pdf. Accessed 2013 Feb 19.
5. Wells M, Williams B, Firnigl D, Lang H, Coyle J, Kroll T, et al. Supporting 'work-related goals' rather than 'return to work' after cancer? A systematic review and meta-synthesis of 25 qualitative studies. *Psychooncology* 2013;22(6):1208-19. Epub 2012 Aug 10.
6. Verbeek J, de Boer A, Taskila T. Primary and occupational health care providers. In: Feuerstein M, editor. *Work and cancer survivors*. New York, NY: Springer; 2011. p. 191-209.

7. Wada K, Ohtsu M, Aizawa Y, Tanaka H, Tagaya N, Takahashi M. Awareness and behavior of oncologists and support measures in medical institutions related to ongoing employment of cancer patients in Japan. *Jpn J Clin Oncol* 2012;42(4):295-301. Epub 2012 Feb 8.
8. De Boer AG, Bruinvels DJ, Tytgat KM, Schoorlemmer A, Klinkenbijl JH, Frings-Dresen MH. Employment status and work-related problems of gastrointestinal cancer patients at diagnosis: a cross-sectional study. *BMJ Open* 2011;1(2):e000190.
9. Groeneveld IF, de Boer AG, Frings-Dresen MH. Physical exercise and return to work: cancer survivors' experiences. *J Cancer Surviv* 2013;7(2):237-46.
10. Tamminga SJ, Bos MM, Plaisier PW, de Boer AG, Fons G, Verbeek JH, et al. A hospital-based work support intervention to enhance the return to work of cancer patients: a process evaluation. *J Occup Rehabil* 2012;22(4):565-78.
11. Sehmer JM. Occupational medicine in Canada. *Can Fam Physician* 2006;52:1113-4. Available from: www2.cfpc.ca/cfp/2006/Sep/vol52-sep-fpwatch-sehmer.asp. Accessed 2014 Jan 20.
12. Thome S. *Interpretive description*. Walnut Creek, CA: Left Coast Press; 2008.
13. Hughes R. Considering the vignette technique and its application to a study of drug injecting and HIV risk and safer behaviour. *Sociol Health Illn* 1998;20(3):381-400.
14. Finch J. The vignette technique in survey research. *Sociology* 1987;21(1):105-14.
15. Schoenberg NE, Ravdal H. Using vignettes in awareness and attitudinal research. *Int J Soc Res Methodol* 2000;3(1):63-74.
16. Pink S. *Doing visual ethnography*. 2nd ed. Thousand Oaks, CA: Sage; 2007.
17. NVivo, version 10 [computer software: qualitative data analysis program]. Cambridge, MA: QSR International; 2012.
18. Canadian Cancer Society's Advisory Committee on Cancer Statistics. *Canadian cancer statistics 2013. Special topic: liver cancer*. Toronto, ON: Canadian Cancer Society; 2013. Available from: www.cancer.ca/~media/cancer.ca/CW/cancer%20information/cancer%20101/Canadian%20cancer%20statistics/canadian-cancer-statistics-2013-EN.pdf. Accessed 2013 Sep 18.
19. Canadian Medical Association. *The treating physicians' role in helping patients return to work after an illness or injury*. Ottawa, ON: Canadian Medical Association; 2013. Available from: <http://policybase.cma.ca/dbtw-wpd/Policypdf/PD13-05.pdf>. Accessed 2014 May 24.
20. Soklaridis S, Tang G, Cartmill C, Cassidy JD, Anderson J. "Can you go back to work?" Family physicians' experiences with assessing patients' functional ability to return to work. *Can Fam Physician* 2011;57:202-9.
21. Townsend EA, Polatajko HJ. *Enabling occupation II: advancing an occupational therapy vision for health, well-being, and justice through occupation*. Ottawa, ON: Canadian Association of Occupational Therapists Publications ACE; 2007.
22. Canadian Partnership Against Cancer. *Programs and resources to facilitate return to work for people with cancer or other chronic diseases: environmental scan*. Toronto, ON: Canadian Partnership Against Cancer; 2012. Available from: www.cancerview.ca/idc/groups/public/documents/webcontent/rtw_environmental_scan.pdf. Accessed 2013 Feb 19.

