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Opinion

Supporting the Return to Work of Breast Cancer Survivors: From a Theoretical to a Clinical Perspective

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Abstract: Promoting the return to work of breast cancer survivors is of major interest to patients, healthcare and occupational health professionals, companies, governments, and researchers worldwide. We previously conducted a French consensus study resulting in a model describing the multifactorial process of the return to work of breast cancer survivors (the REWORK-BC model). Other work has identified the transtheoretical model as a relevant theoretical framework for interventions to promote the return to work of cancer survivors. In this opinion paper, we provide a theoretically-based clinical framework describing how to support breast cancer survivors at each stage of the return-to-work process. This clinical framework considers several essential aspects of supportive care for breast cancer survivors returning to work, such as: (i) helping the patient actively self-manage, by considering her to be the main decision-maker; (ii) respecting and adapting to the patient's choice of professional project; (iii) respecting the temporality of the patient's choices; (iv) proposing tailored interventions; (v) implementing simple tools to promote the return to work, shared representation between the patient and a multidisciplinary team, and improvement of working conditions and the knowledge of health and occupational professionals, and managers or employers; and (vi) maintaining certain flexibility aimed at proposing, but never imposing, changes in practices. This clinical framework, specific to breast cancer survivors, could be extrapolated to other tumor types, offering a practical guide for healthcare and occupational health professionals to better understand the return-to-work process of cancer survivors. This clinical framework aims to be a usable tool for any hospital or cancer care center wishing to implement a patient-centered intervention that promotes returning to work, regardless of the country.

Keywords: breast cancer; survivors; return-to-work; clinical framework



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1. Introduction

Over the two past decades, improvements in breast cancer treatments have led to an increase in patient survival [1,2]. For most working-age breast cancer survivors (BCSs), treatments and their long-term side effects can make it difficult to return to work (RTW) [3–5]. Scientific investigations have identified several determinants of BCSs' RTW, and the role of each stakeholder involved in the process, namely the BCS, healthcare and occupational health professionals, and managers/employers [3,6,7]. Healthcare professionals within the hospital, as well as occupational health professionals and managers within the company

play an important role in providing advice, support, and functional and emotional assistance to the BCSs in the RTW process [8,9]. However, they highlight a lack of knowledge, skills, and tools to support the sustainable RTW of BCSs [6,10].

Interventions to promote RTW for BCSs must be theory-based and patient-centered [11–13]. Duijts et al. identified the Transtheoretical Model of Behavior Change (TTM) as a relevant theoretical framework for developing these interventions [14,15]. A recent qualitative study endorses the value of tailoring support for the work participation of cancer survivors along the stages of change described by the TTM [16]. However, the TTM alone cannot account for all the complexities of behavior change, particularly when studying the multidimensional process of RTW [13,14]. The recently proposed multidimensional REWORK-BC model may complement the TTM by providing a multidisciplinary framework to assess each determinant at the appropriate time, and facilitate supportive care for BCSs' RTW [13].

2. Aims

We here aim to propose a multidimensional framework for managing the RTW of BCSs from both a theoretical and clinical perspective. After presenting the TTM, the REWORK-BC model, and their complementarity, we will suggest the determinants to be assessed at each stage of the RTW process as well as the assessment indicators for each stage of the process will be suggested.

3. A Theoretical Perspective

3.1. The Transtheoretical Model

The TTM describes the following six stages of change, with varying temporality [14]:

- Stage 1—Precontemplation: no intention to change behavior within the next six months.
- Stage 2—Contemplation: intention to change behavior in the next six months.
- Stage 3—Preparation: intention and plans to act in the near future, (i.e., around one month).
- Stage 4—Action: behavior has changed within the past six months, with a high risk of relapse.
- Stage 5—Maintenance: new behavior undertaken for more than six months and prevention of relapses, which are less frequent.
- Stage 6—Termination: no temptation to relapse and full confidence to maintain the new behavior [14].

The notion of relapse is an integral part of the process and must be well managed and de-dramatized to prevent people from abandoning the change process altogether [14].

In addition, change processes are often omitted in TTM evaluations even though they facilitate the transition from one phase to another and thus constitute the objectives to be progressively achieved during therapeutic support [14]. Empirical studies describe ten change processes involved in the TTM as follows [14,17–19]:

- The transition from the precontemplation phase to the contemplation phase depends on consciousness-raising, dramatic relief, and environmental reevaluation that can be enhanced by awareness campaigns, testimonials, (e.g., by peer support), or transmission of information.
- To reach the preparation phase, the patient sets up a process of self-reevaluation which can be enhanced by clarifying her values.
- Self-liberation, indicating that the patient is convinced that she can act.
- Maintenance can be achieved if counterconditioning, (e.g., by increasing assertiveness strategies), helping relationships, reinforcement management, (e.g., through peer recognition and support), and stimulus control, (e.g., by changing the environment) are adopted.
- Social liberation, requiring an increase in social opportunities and alternatives, especially for people who are relatively deprived or oppressed. This process may require several stages of change [14].

According to the TTM, progression through the stages of change and achievement of change processes is based on: (i) perception of the benefits and drawbacks of changing behavior, (i.e., decisional balance); (ii) feeling to be able to progressively achieve the steps necessary for change, (i.e., self-efficacy), which should increase over time; and (iii) intercurrent events that may make it difficult to change [14].

3.2. The REWORK-BC Model

The REWORK-BC model emerged from a French expert consensus [13]. This conceptual model offers an integrative, dynamic, and multidisciplinary perception of the RTW of BCSs [13]. Its strength lies in putting individual capacities into perspective with work demand, thus defining the Margins of Maneuver (MM) for the RTW [20,21]. It implements (i) the initial MM corresponding to the work situation experienced before the cancer diagnosis; (ii) the therapeutic MM corresponding to the gain of MM following the implementation of supportive care and/or accommodations in the work environment to facilitate RTW; and (iii) the final MM corresponding to the readjustments of the working situation after RTW, that are necessary for sustainable job retention [13,20,21]. In addition, the REWORK-BC model articulates from a transactional perspective: (i) dispositional variables, (e.g., socio-demographic, socio-professional, financial, medical); (ii) a primary appraisal related to work ability; (iii) a secondary appraisal corresponding to individual and social resources; (iv) individual and professional adjustments strategies; (v) outcomes in terms of RTW or non-RTW; and systematic feedback providing the dynamics of work ability, resource and adjustment strategy re-evaluations [13].

3.3. Complementarity between TTM and REWORK-BC Models

The TTM is a generalist model of behavior change that has been widely proven in framing interventions to promote health behaviors in patients diagnosed with cancer [22–25]. It adds a temporal aspect to the REWORK-BC model, enabling an intervention aimed at promoting the RTW of BCSs to be framed. In turn, the REWORK-BC model is very specific to the RTW of BCSs, providing several typologies of BCSs regularly encountered in clinical practice and the precise elements to be evaluated at each stage of change [13]. It offers a specific clinical view and favored patient-centered interventions [13]. Both models will consider some form of re-evaluation of the situation: (i) the TTM through the consideration of relapses to the previous stage of behavior [14]; and (ii) the REWORK-BC model taking systematic feedback into account [13].

4. A Clinical Perspective

We argue that promoting the RTW of BCSs is essentially based on three aspects: (i) enhancing the health-related quality of life [26,27]; (ii) adjusting the work situation, work organization, and management practices [6,28,29]; and (iii) coordinating stakeholders, (i.e., BCSs, healthcare professionals and managers), while considering the specific needs of each patient.

Because of the multiplicity of the stakeholders, and their varying perspectives on the situation, the coordination may be complex. A protocol that is too strict and a course of action that is too standardized might lead to a lack of agility during the RTW process. Indeed, RTW expectations vary according to individual situations, companies, legislation, and insurance systems [13,30–32]. Consequently, we argue that RTW support for BCSs should be based on a sufficiently flexible clinical framework and the provision of a range of simple tools. The tools made available must: (i) meet the specific needs of each stakeholder; and (ii) suggest, without imposing, ways of improving practices.

4.1. Functionality of Simple Tools

Table 1 shows the different simple tools included in the clinical framework and their functionality at each stage of the RTW process.

Table 1. Functionality of simple tools.

TTM Phase	Process to Achieve	Simple Tool	Functionality
1. Precontemplation	• Consciousness-raising	• Poster in medical offices	• Encourage the BCS to talk about her RTW with her referring physician as soon as possible.
	• Dramatic relief	• Informative booklet or leaflet [33]	• Convey essential information about the RTW process.
	• Environmental re-evaluation	• Website (e.g., MiLES) [9,28,29]	• Share testimonials from patients and managers who have been through the same process.
2. Contemplation	• Self-re-evaluation	• Follow-up booklet	• Inform the manager, as soon as possible, about good managerial practices (only if the patient agrees to pass them on).
			• Provide an opportunity for the manager to seek assistance in promoting a sustainable RTW (only if the patient agrees to pass them on).
			• Keep a written record of the values and be aware of the evolution throughout the reflection (Table 3).
3. Preparation	• Self-liberation	• Screening tool [13]	• Encourage shared representation with the RTW coordinator.
		• Follow-up booklet	• Identify the most appropriate procedure for the BCS (Table 4).
		• Website (e.g., MiLES) [9,28,29]	• Keep a written record; be aware of the evolution throughout the tailored intervention.
4. Action	• Counterconditioning • Helping relationships • Reinforcement management • Stimulus control	• Screening tool	• Encourage shared representation with the multidisciplinary team involved in the tailored intervention.
		• Follow-up booklet	• Prepare the pre-RTW visit with the occupational health physician.
		• Website (e.g., MiLES) [9,28,29]	• Inform the manager of good managerial practices (only if the patient agrees to pass them on).
5. Maintenance		• Screening tool	• Provide an opportunity for the manager to seek assistance in promoting a sustainable RTW (only if the BCS agrees to pass them on).
		• Follow-up booklet	• Carry out the necessary reassessments (Tables 3 and 4).
		• Website (e.g., MiLES) [9,28,29]	• Keep a written record; be aware of the evolution throughout the tailored intervention.

Notes. MiLES: the Missing Link: optimizing RTW of Employees diagnosed with cancer, by Supporting employers.
TTM: Transtheoretical Model of Change.

The implementation of the set of tools would build on both the steps and processes of the TTM and the assessment elements of the REWORK-BC model, to facilitate the RTW

process of BCSs while considering the readjustment phases, (i.e., feedback, whether there are behavioral relapses or not) [13]. The clinical implications and elements to be assessed at each stage of the process are detailed below.

4.2. Stage 1—Precontemplation

At this point, the patient has generally just been diagnosed and is beginning her care journey. The focus is on care, with the main objective being recovery. Consequently, the RTW is not yet envisaged [5,15].

Promoting the achievement of the contemplation phase. The patient's awareness of the importance of preparing for the RTW at an early stage must be promoted. Posters could be put up in healthcare professionals' offices which would lead the patient to talk about it as early as possible (Table 1). An informative booklet or leaflet with a website that summarizes, with respect to medical privacy, key information and testimonials from patients, RTW specialists, and managers could also be helpful (Table 1) [33]. The patient would be able to consult these materials, which are available to them, whenever they feel the need. On the website, there could be a page dedicated to managers and employers indicating the main actions to be taken, at each stage of the disease, to support the RTW of the employee diagnosed with breast cancer, (e.g., the Missing Link: optimizing RTW of Employees diagnosed with cancer, by Supporting employers—MiLES intervention) [9,28,29]. Patients could be invited to forward this web page to their supervisors if they so wish.

4.3. Stage 2—Contemplation

Breast cancer patients expect to RTW within six months, usually after completion of chemotherapy [5,15]. At this stage, the main contacts are the oncologist, the radiotherapist, the general practitioner, and/or the occupational health physician. Simple information can be collected in the medical file by these professionals (Table 2). Recording the socio-demographic, socio-professional, and financial characteristics will enable them to identify BCSs who need special attention, based on prognostic factors of adverse occupational outcomes, and allow an early contact with a social worker, if necessary, in order to start the administrative and financial procedures, (e.g., financial emergency).

Table 2. Reminder of the variables to be recorded in the medical file.

Socio-demographic	<input type="checkbox"/> Age <input type="checkbox"/> Ethnicity <input type="checkbox"/> Dependent children	<input type="checkbox"/> Education <input type="checkbox"/> Place of residence <input type="checkbox"/> Social precariousness
Professional	<input type="checkbox"/> Socio-professional category <input type="checkbox"/> Company size <input type="checkbox"/> Seniority in the company	<input type="checkbox"/> Professional status <input type="checkbox"/> Type of contract <input type="checkbox"/> Hierarchical position
Financial	<input type="checkbox"/> Income	<input type="checkbox"/> Main family breadwinner
Medical	<input type="checkbox"/> Cancer stage <input type="checkbox"/> Type of surgery <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Immunotherapy	<input type="checkbox"/> First cancer diagnosis or more <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Hormone therapy <input type="checkbox"/> Targeted therapy (e.g., Trastuzumab)

Recording the medical characteristics will enable the potential physical and psychological side effects of treatment affecting the RTW, (e.g., fatigue, pain, emotional distress) to be predicted [34,35]. For those healthcare professionals lacking the time and knowledge to have an in-depth discussion on the RTW [10], one solution would be to propose a referral to an RTW coordinator (e.g., nurse, social worker, psychologist) to support each patient in her RTW process [36,37]. Durand et al. recently identified the main competencies of the RTW coordinators, namely [37]:

- *Competency 1:* Tailoring practices to the needs of the BCSs throughout the RTW process.
- *Competency 2:* Involving the workplace stakeholders as much as possible.

- *Competency 3:* Rethinking/questioning practices and ideas regarding the RTW process and, as much as possible, inviting the stakeholders in the hospital and the workplace to do the same.
- *Competency 4:* Developing practices that comply with laws, regulations, agreements, and specific procedures related to the BCSs' RTW process.

Promoting the achievement of the preparation phase: assess and clarify values (Table 3).

The main objective of the first interview with the RTW coordinator is to assess and clarify the patients' values regarding their work. The goal is to better understand the patient's professional project and to discuss the financial consequences of their decision. In our clinical practice, we have identified several types of career plans:

- Returning to previous work. An initial assessment of the RTW self-efficacy may be relevant in order to establish a basal score and better understand the feelings surrounding RTW [38].
- Disability pension, or early retirement for the oldest patients [39]. Contact with a social insurance physician, a social worker, or even a lawyer can be proposed to prepare the request for disability or early retirement as best as possible.
- A wish to change positions, companies, or jobs [40,41]. The wish to change one's professional life can be explained by a change in life philosophy due to the diagnosis and treatment of cancer, conceptualized as post-traumatic growth [40–42]. It will also be a matter of helping the patient to identify new professional opportunities, (i.e., social liberation) before hoping to reach the preparation phase [14]. Contact with a social worker or a service specialized in professional integration could be helpful.

Table 3. Discussion points for value clarification.

<input type="checkbox"/> Intention to RTW
<input type="checkbox"/> Meaning of work
<input type="checkbox"/> Work attachment
<input type="checkbox"/> Sense of professional usefulness
<input type="checkbox"/> Post-traumatic growth
<input type="checkbox"/> Wage losses and/or financial consequences
<input type="checkbox"/> RTW self-efficacy (if necessary)

To create a good therapeutic alliance, it is important to respect the patient's choice and to give her the necessary time for reflection to motivate her to begin the preparation phase, whatever the decision. If necessary, several appointments can be scheduled to support the reflection on the clarification of values and the RTW project. It is important that the main elements of the discussion be recorded and validated by the patient in a follow-up booklet (Table 1). This allows both the patient and the RTW coordinator to report on the evolution of the reflections regarding the values related to the future professional project.

4.4. Stage 3—Preparation

When the BCS feels ready to prepare her RTW, the RTW coordinator can offer a tailored intervention [11,12,43]. The objective is twofold: (i) to promote work ability by improving health-related quality of life, according to the BCS's needs [13]; and (ii) to promote adjustments to the work situation, work organization, and management practices as much as possible [9].

Promoting work ability by improving health-related quality of life. Interventions promoting health-related quality of life are well known (e.g., physical activity, psychological support, peer support, etc.) [26,27]. However, it is more complex to tailor these interventions to the patient's specific needs. A screening tool, specifically designed to assess the main determinants of RTW, could be proposed and recorded in the follow-up booklet in order to identify the most appropriate intervention (Table 1) [13]. This screening tool will allow a multidisciplinary working group, (i.e., RTW coordinator, healthcare professionals, occupational health physician, specialized nurse, psychologist, ergonomist, physical

activity specialist, physiotherapist, social worker) to propose several support options to the BCS [8]. The BCS will choose the one (or those) she is most motivated to carry out, since motivation is an important prognostic factor of adherence to supportive care [44].

Promoting adjustments to the work situation, work organization, and management practices as much as possible. BCSs have no legal obligation to precisely specify the reasons for their sick leave to their employer [30]. It is ethically and legally inappropriate for healthcare professionals to directly contact the manager or employer of an employee who has been diagnosed with cancer without the patient's consent [45], even to propose tools to support the sustainable RTW. Such contact should be legally established by the BCS herself, or via the occupational health physician with the consent of the patient, while considering medical privacy. The BCS is then free to choose whether or not to pass on the necessary information to her manager. It is therefore possible to remind her that she can pass on the informative website to her manager transmitted during the pre-contemplation phase (Table 1), in which a section is reserved for managers and employers, (e.g., MiLES) [9,28,29]. If accepted, the manager is then free to consult this website. It is also possible to include the contact details of the RTW coordinator, occupational health physician, work psychologists, or ergonomists, in case of additional questions or even more individualized support for the manager.

Identifying both health- and work-related difficulties (Table 4). All the variables are listed in Table 4.

Table 4. Reminder of the variables to be recorded at the preparation phase.

Physical abilities	<input type="checkbox"/> Overall health status <input type="checkbox"/> Physical fatigue <input type="checkbox"/> Disability due to BC (physical sequelae, pain, restricted arm movement)
Psychological abilities	<input type="checkbox"/> Emotional distress (anxiety, depression) <input type="checkbox"/> Emotional fatigue <input type="checkbox"/> Cognitive fatigue <input type="checkbox"/> Body image
Working conditions	<input type="checkbox"/> Work-related stressors (physical, psychological, organizational)
Others	<input type="checkbox"/> Wage loss <input type="checkbox"/> Quality of the care journey (and the met supportive care) <input type="checkbox"/> Any other elements to be noted in a qualitative way
Resources	<input type="checkbox"/> RTW self-efficacy <input type="checkbox"/> Perceived social support (colleagues, managers, medical staff, family, friends) <input type="checkbox"/> Recognition by colleagues and/or managers
Adjustments	<input type="checkbox"/> Coping (benefit finding, problem-focused, emotion-focused) <input type="checkbox"/> Work accommodations (working time, workstation, professional duties)

The relationship between the physical/psychological abilities of the BCSs and the former work situation in terms of initial MM will provide a first assessment of the RTW situation (Figure 1) [13]. Wage loss and quality of the care journey (including the quality of the met supportive care) should complement this assessment as they may be perceived as sources of stress that impact the BCS' psychological health [46,47]. As each BCS is unique, other elements that are not mentioned in the REWORK-BC model can also be noted in a more qualitative way, (e.g., health problems other than cancer, possible relationship problems within the couple or family, children's school difficulties, health problems of the spouse, children or any other family member).

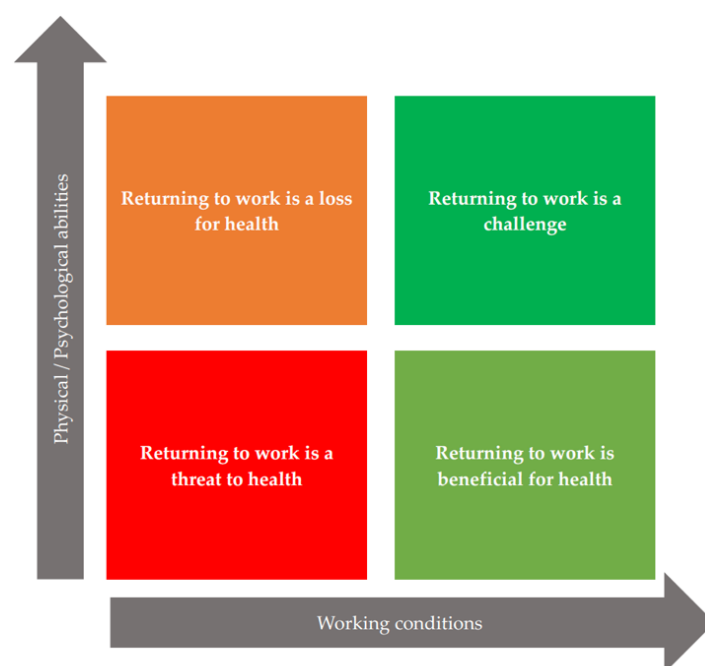


Figure 1. Profiles of patients according to physical/psychological abilities and working conditions.

Considering individual, social and financial resources will help to nuance the first assessment [13]. The intervention proposal will therefore have to consider whether the BCS feels able to RTW and whether she is well supported. Finally, it is essential to assess individual coping skills and work accommodation options [48]. It should be remembered that some BCSs can be successful in the RTW on their own, against all expectations [13,49].

Promoting the achievement of the action phase: self-liberation. In accordance with the TTM and REWORK-BC models, a tailored intervention will aim to improve work ability and resources so that the BCS' RTW self-efficacy and coping skills will increase [13,14]. All elements questioned (Table 4) must be re-evaluated as many times as necessary during the preparation phase (time intervals to be determined by the multidisciplinary team and by the BCS herself) and noted in the follow-up booklet (Table 1). This will allow the BCS, and the multidisciplinary team to see the progress. As soon as the RTW is identified as beneficial for health (Figure 1) and the BCS feels able to RTW, the pre-RTW visit can take place and will be facilitated by the elements annotated in the follow-up booklet (Table 1). The occupational health physician can then set a date for the RTW in agreement with the BCS and the employer, and make the final work accommodations necessary for a successful RTW [13,48]. For patients in a situation where the RTW is a threat to their health (Figure 1), and/or who do not wish to return to their former work, supporting intervention towards a change of employment, (e.g., social worker, occupational psychologist, specialized devices) is essential to prepare future job recruitment [14].

4.5. Stage 4—Action

At this point, the BCS has returned to work but is likely to be on sick leave several times [50]. It is therefore necessary for the RTW coordinator or the occupational health physician to offer her regular appointments in order to make an overall assessment of her values about work, her work ability, the resources at her disposal, and her coping skills (Tables 3 and 4) [13]. All these elements must be filled in the follow-up booklet (Table 1). This will allow the necessary adjustments to be made for a sustainable RTW, (i.e., sufficient final MM). In case of sick leave, the follow-up appointments will reassure the BCS by explaining that it is part of the process [14], that there is no right or wrong way to RTW; the important thing being to preserve her health. In some cases, BCSs will start the process again with the goal of changing their professional life.

Promoting the achievement of the maintenance phase. Regular motivational appointments can be organized by the RTW coordinator or the occupational health physician to help the BCS assert herself. They can also provide advice on how to better organize her work, given the long-term side effects (especially physical and cognitive fatigue) [4,34]. It is also preferable to modify the work environment, (e.g., change the layout of the office, have new assignments) [48]. To achieve this, relationships with managers and colleagues must be favorable [6,9]. Managers or employers who have agreed to participate in the program, (e.g., MiLES) may also be offered counseling if the information made available on the website does not seem sufficient (Table 1) [9,28,29].

4.6. Stage 5—Maintenance

The maintenance phase is relatively similar to the action phase. Because sick leave is less frequent, the time intervals between interviews are longer. Follow-up appointments are recommended but should be done with the needs and preferences of the BCS. The elements must be noted in the follow-up booklet (Table 1) and transmitted to the occupational physician so that he/she can make progressive readjustments.

4.7. Stage 6—Termination of the Process

The process ends when: (i) the BCS has not been off work, due to cancer and its treatments, for more than six months; (ii) the BCS is satisfied with the new sustainable working situation; and (iii) the BCS demonstrates satisfactory health- and work-related quality of life [51].

5. Measurements and Assessment Indicators for Each Stage of the Process

Regarding the REWORK-BC model, many psychosocial variables need to be collected throughout the process [4,13]. Some questionnaires are commonly used in oncology or occupation health studies for assessing these psychosocial variables, for example, the EORTC-QLQ-C30, (i.e., quality of life) [52], the Hospital Anxiety and Depression Scale [53], the Multidimensional Fatigue Inventory [54,55], the Post-traumatic Growth Inventory [56–58], the Body Image Scale [59], the RTW Self-Efficacy scale [38,60,61], the Cognitive Symptom Checklist-Work [62,63], the Job Content Questionnaire [64], or the Copenhagen Psychosocial Questionnaire [65,66]. However, filling out numerous questionnaires, although submitted sequentially, may be cognitively challenging for BCSs who have potentially been treated with chemotherapy [67]. In this sense, we encourage the use of short forms of questionnaires, and future research to propose more flexible assessment strategies, facilitating the collection of information from patients and allowing time for discussion from a clinical perspective.

In addition, some indicators of the progress of the BCS in the different stages of change of the TTM [14] could also be proposed as follows:

- *Stage 2—Contemplation:* the BCS mentions the issue of the RTW and indicates that the documents and websites made available to her were instrumental in getting her to talk about it. The BCS also provides the necessary information to her manager or employer.
- *Stage 3—Preparation:* the BCS indicates that she is clear with her values and testifies to a good therapeutic alliance with the RTW coordinator. Contact is established with the manager.
- *Stage 4—Action:* the BCS has a greater RTW self-efficacy than before the preparation, her health-related quality of life is favorable, and the manager or employer is prepared to welcome her under good working conditions.
- *Stage 5—Maintenance:* the BCS shows a good health- and work-related quality of life after RTW. Sick leave due to cancer and its treatment is less frequent.
- *Stage 6—Termination of the process:* the BCS shows a good health- and work-related quality of life. There is no more sick leave due to cancer or its treatment.

6. Conclusions

The proposed clinical framework is based on: (i) a relevant theoretical model frequently used for promoting the health-related quality of life of cancer patients and survivors, (i.e., TTM); (ii) a model specific to the RTW process of BCSs based on expert consensus, (i.e., REWORK-BC model); and (iii) the scientific literature focusing on the RTW of BCSs. It offers all healthcare and occupational health professionals a practical guide to better understand the RTW process of BCSs. By adapting the determinants related to the medical treatments and some specific side effects, we argue that this clinical framework could be extrapolated to other tumor types. The flexibility of the framework and the implementation of simple tools, either already available or to be developed in future studies, make it adaptable to various health systems around the world. While this clinical framework is partly based on a model resulting from a French consensus, it aims to be a usable tool for any hospital or cancer care center wishing to implement a patient-centered intervention to promote the RTW of BCSs, regardless of the country.

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