Barriers and facilitators to return to work following cardiovascular disease
a systematic review and meta-synthesis of qualitative research
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Published in:
BMJ Open

DOI:
10.1136/bmjopen-2022-069091

Publication date:
2023

Document version
Publisher's PDF, also known as Version of record

Document license:
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Citation for published version (APA):
ABSTRACT

Objectives  Return to work is a key rehabilitation goal, however, people recovering from cardiovascular disease (CVD) often struggle with returning to work. The aim of this study was to conduct a systematic review and meta-synthesis of the existing qualitative evidence on barriers and facilitators to return to work experienced by people with CVD.

Methods  A systematic literature search was conducted in PubMed, Embase, Web of Science, PsycINFO, Scopus and CINAHL in August 2022. The reference lists of the included articles were searched. The Critical Appraisal Skills Programme was used for quality appraisal and a meta-synthesis was employed.

Findings  This review includes 15 studies of overall high methodological quality. Barriers covered four themes: physical limitations, psychological and relational factors, the working context and support within health and social care systems. Facilitators were related to five themes: return to normality, enhancing well-being, financial concerns, the working context and support within health and social care systems.

Conclusion  Our findings highlight that return to work following CVD is a complex process influenced by individual factors, as well as work-related factors, factors in the health and social care systems and social security policies and regulations. To improve return to work, this review illustrates a need for individualised, multidisciplinary and coordinated vocational rehabilitation programmes that accommodate potential barriers to re-employment. Similarly, this review highlights how vocational rehabilitation programmes should ensure individualised information and support early in the rehabilitation process, as well as the importance of engaging relevant stakeholders, such as employers, in making individualised return-to-work plans.

INTRODUCTION

Cardiovascular disease (CVD) constitutes a substantial disease burden with approximately 523 million cases worldwide, and is a leading cause of global mortality, despite improved survival rates. CVD is increasingly common in the working-age population, and for these individuals returning to work is often a significant rehabilitation goal. Return to work may facilitate a sense of normality, and is crucial for self-esteem, social identity and quality of life. Adding to this, return to work is of great societal importance, as CVD is associated with significant costs caused by patients being absent from work.

As described in contemporary models of work disability, such as the Sherbrooke model, returning to work is a complex process shaped by multiple factors on both micro, meso and macro level. Predictors of return to work have been explored in recent quantitative studies, and factors specifically associated with non-return to work include female gender, older age, lower educational level and low income. In addition, many people with CVD feel pressured to return to work, and face numerous barriers, including physical and psychological limitations, comorbidities and lack of support at the workplace or from cardiac rehabilitation programmes.

While return to work following CVD has mainly been explored in quantitative studies,
and surveys,\textsuperscript{10–18} qualitative studies have previously investigated patients’ experiences of returning to work after CVD. However, to our knowledge, no systematic review has summarised the totality of evidence from the perspective of the individual. Understanding and categorising the factors that shape the return-to-work process following CVD is complex as factors interact and differ in importance as experienced by the patient. In addition, it is difficult to make a clear distinction between barriers and facilitators, as some factors might have a positive impact on return to work for some individuals and a negative impact for others. To improve vocational rehabilitation, there is a need to identify factors that hinder (barriers) and promote (facilitators) return to work after a CVD diagnosis. As such, the aim of this study was to conduct a systematic review and meta-synthesis of the existing qualitative evidence on barriers and facilitators to return to work for people with CVD.

**METHODS**

The reporting of this systematic review follows the Preferred Reporting Items for Systematic reviews and Meta-Analyses\textsuperscript{20} and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research statements\textsuperscript{21} (see Research Checklist, online supplemental file A).

**Study selection criteria**

Eligible studies were defined as those including participants diagnosed with CVD (ischaemic heart disease, heart valve disease, heart failure or atrial fibrillation) of working-age (35–65 years), who were in paid employment before CVD-diagnosis. Studies with mixed populations where not all participants had engaged in paid work prior to diagnosis were also included, but only findings pertaining to the return-to-work process for those working prior to diagnosis were extracted from these studies. Eligible studies addressed barriers and/or facilitators associated with return to work. Studies where participants had not returned to work yet or had decided not to return were also included to ensure that barriers experienced by people on sick leave and by people who had left the workforce following their CVD were also explored. Eligible studies applied a qualitative or mixed-methods design and were published in Danish, English, Swedish, Norwegian or German. Studies were limited to those published in the past 11 years (2011 to August 2022) to ensure that the barriers and facilitators identified reflected contemporary issues, in particular changes in models of cardiac rehabilitation, policies related to sick leave and increasing retirement ages in many countries. Lastly, to ensure comparability in employment status prior to CVD, as this is expected to affect subsequent return-to-work experiences, we excluded studies that only considered unpaid work, such as volunteer work.

**Information sources and search strategy**

A preplanned and comprehensive, systematic literature search was conducted on 30 August 2022 in the following search engines: PubMed, Scopus, CINAHL (through EBSCOhost), PsycINFO (through EBSCOhost), Web of Science and Embase. Together these databases index a broad scale of qualitative and mixed-methods publications within the area of healthcare, occupational health and work reintegration.

The search-strategy contained exhaustive keyword combinations for each of the two concepts of interest, CVD and return to work. The searches included combinations of the following keywords related to CVD and return to work: heart patient OR cardiac patient OR heart disease OR cardiovascular disease AND return to work OR vocational rehabilitation OR work participation OR work reintegration OR employment. The full search strings used in each database are available in online supplemental file B.

**Data collection process**

The search was conducted by two reviewers (EBA and SMBJ), and the software tool Covidence was used for data management and selection of studies. First, titles and abstracts of the identified studies were imported, full texts were removed. After title/abstract screening, full texts of potentially relevant studies were assessed. If consensus was not reached between the two reviewers (EBA and SMBJ), a third reviewer was consulted (MK). Finally, the reference lists of the studies selected for inclusion were searched for additional relevant studies. The detailed data collection process is visualised in figure 1.

**Descriptive information, data items and synthesis of results**

Two reviewers (EBA and SMBJ) independently extracted descriptive information from each study, including study design, objectives, number and characteristics of participants, and findings pertaining to the return-to-work process.
of participants, including type of CVD, as well as pre-
diagnosis employment status, return-to-work status and
research methods. Additionally, a summary of the original
findings was provided for each included study (please see
table 1 and online supplemental table 1S, online supple-
mental file C). In this systematic review we employed a
meta-synthesis in which unaltered texts of the included
studies formed the data for analysis.22 Two reviewers
(EB and SMBJ) independently extracted data related to
facilitators or barriers to returning to work from the
result sections of the included studies. Regarding studies
applying a mixed-methods design, only the qualitative
results were extracted for synthesis. Subsequently, going
through the identified barriers and facilitators line-by-
line, themes were discussed and established in a consensus
discussion (EB and SMBJ). Using an inductive approach
when generating themes, related barriers and facilitators
were grouped, categorised into relevant overarching
themes and summarised into main findings.

Quality appraisal
The quality of the studies included in this review was
evaluated using the Critical Appraisal Skills Programme
(CASP), which is appropriate when conducting health-
related qualitative syntheses.23 Regarding the mixed-
methods studies, only the qualitative components of these
studies were assessed using CASP. The quality appraisal
aimed to assess the reporting, methodological rigour and
conceptual consistency of the studies. Studies were
classified as being of high, medium or low quality if ≥8,
5–7 or ≤4 of the questions in the CASP tool could be answered
positively (‘yes’ or ‘somewhat’). Two reviewers (EB and
SMBJ) independently appraised the selected studies,
whereafter consensus was reached.

Patient and public involvement
Patients or the public have not been directly involved
in this specific publication. However, the study is part of
a larger research project within The Danish Heart Foun-
dation, which is a patient organisation that substantially
involves patients, relatives and other relevant stakeholders
in research and policy activities. Furthermore, to ensure
that the findings of the present study are widely dissemi-
nated in order to inform practice, we will involve relevant
members of the public in dissemination activities.

RESULTS
Study selection
The initial search yielded 3982 publications, of which
1057 were excluded based on duplication. The remaining
2925 were then screened based on title and/or abstract,
resulting in the exclusion of 2876 publications. Two
reviewers (EB and SMBJ) independently assessed the
full text of the remaining 49 publications. Subsequently,
35 publications were excluded due to wrong study design,
type of publication, language, population, irrelevance or
because we were unable to locate the publications. The
reference lists of the 14 remaining studies were then
searched, and 1 additional study was included.24 Thus, 15
studies were included in the review. Two of the studies
were based on the same primary data. However, they were
included as two separate studies as they are published
in separate papers with different aims and analytical
focus.25 26 Figure 1 visualises the systematic search and
screening process.

Study characteristics
The characteristics of the 15 included studies are
presented in table 1 and online supplemental file C. Most
studies were conducted in European countries (n=8),
with the remaining being conducted in Canada (n=3),
Australia (n=2), Turkey (n=1) and Singapore (n=1).
All studies included participants who had worked prior
to diagnosis, with 10 studies including mixed popula-
tions with both working and none-working participants.
Studies included between 6 and 93 participants (median
23 participants), with a total of 501 participants across
all studies. Participants’ age ranged from 35 to 83 years,
and the studies covered a variety of CVD diagnoses, for
example, acute coronary syndrome, acute myocardial
infarction, out-of-hospital cardiac event, heart failure
and ischaemic chest pain. Some studies did not specify
the type of CVD. All studies were published between
2011 and 2022 and were based on qualitative methodol-
ogies. A mixed-methods design was applied in three of
the studies.27 29 Regarding the quantitative components
of these studies, only two explored factors associated
with returning to work,28 29 whereas the third focused on
patients’ symptoms and needs in the early rehabilitation
phase.27

Appraisal of studies
A summary of the methodological quality assessment of
each study according to the CASP-tool is shown in online
supplemental file D). Most of the studies were assessed
to be of high quality. Only two studies were assessed to
be of medium quality. All studies had a clear statement
of the research aim and applied appropriate qualitative
methodology. In addition, all studies clearly described
the recruitment strategy, data collection procedure and
included a clear statement of findings. Most of the studies
reported that ethical approval was obtained. However, the
relationship between the researcher and the participants,
such as whether the researcher critically examined their
own role, was only adequately evident in five studies.

Synthesis of results
Most studies identified both barriers and facilitators to
return to work, while two studies only described either
barriers or facilitators. In most studies, barriers and fac-
ilitators appeared in descriptions of participants’ lived
experiences of recovering from CVD, while two studies
had a more explicit focus on participants’ return-to-work
process. While barriers and facilitators on micro and meso-
level were identified in 15 and 11 studies, respectively, only
<table>
<thead>
<tr>
<th>Author, year</th>
<th>Design</th>
<th>Country</th>
<th>Participants (n, sex, diagnosis, age)</th>
<th>Pre-diagnosis employment status described</th>
<th>Return-to-work status described</th>
<th>Findings (facilitators to return to work)</th>
<th>Findings (barriers to return to work)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Şahan et al⁵⁴ (2016)</td>
<td>Qualitative study</td>
<td>Turkey</td>
<td>N=12; M=12, AMI=12; Age: 32–49</td>
<td>Yes</td>
<td>9=RTW at time of study.</td>
<td>► Economic reasons.</td>
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<td></td>
<td>► Male gender roles; being the breadwinner of the family.</td>
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<tr>
<td>2. Pryor et al⁷⁷ (2014)</td>
<td>Qualitative study</td>
<td>Australia</td>
<td>N=9; F=5, M=4; AMI=8; Ischaemic chest pain=1; Age: 39–71</td>
<td>Partially*</td>
<td>Partially.*</td>
<td>► A desire to get life back to normal.</td>
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<td></td>
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<td></td>
<td></td>
<td>► Debilitating tiredness hinder everyday activities.</td>
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<tr>
<td>3. Siebus et al⁵⁵ (2012)</td>
<td>Qualitative study</td>
<td>The Netherlands</td>
<td>N=84; F=9, M=75, ACS=84; Mean age: 55</td>
<td>Yes</td>
<td>58%=RTW within 3 months.</td>
<td>► No reports.</td>
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<td>► Information given by doctors.</td>
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<td></td>
<td>► Work adjustments and environment.</td>
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<td></td>
<td>► Supportive colleagues.</td>
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<td>► Financial concerns.</td>
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<td></td>
<td>► Physical and mental impairment.</td>
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<td></td>
<td></td>
<td>► Medical restrictions.</td>
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<tr>
<td>6. Boot et al³⁶ (2016)</td>
<td>Mixed-methods study</td>
<td>The Netherlands</td>
<td>N=5; M=4; F=1; CVD=5; Mean age: 55–63</td>
<td>Yes</td>
<td>3=RTW at time of study.</td>
<td>► Economic reasons, and purpose in life.</td>
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<tr>
<td></td>
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<td></td>
<td>► Work adjustments and characteristics.</td>
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<td></td>
<td>► Work as a distraction.</td>
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<td></td>
<td>► Support from supervisor and colleagues.</td>
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<td>7. Neo et al²⁹ (2020)</td>
<td>Qualitative study</td>
<td>Singapore</td>
<td>N=41; LVAD patients=30; caregivers=11; M: 83% of patients; Mean age: 56</td>
<td>Partially*</td>
<td>12=working full-time or part-time at time of study.</td>
<td>► Professional support.</td>
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<td>► Economic reasons.</td>
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<td>► Obtain self-confidence.</td>
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<td>► Being meaningfully occupied.</td>
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<td>► Increased awareness of the LVAD.</td>
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<td>8. Solano-Ruiz et al³⁰ (2021)</td>
<td>Qualitative study</td>
<td>Spain</td>
<td>N=14; M=14; AMI=14; Mean age: 54.7</td>
<td>Yes</td>
<td>4=RTW at time of study.</td>
<td>► Inability to work/early retirement due to disability.</td>
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Continued
<table>
<thead>
<tr>
<th>Author, year</th>
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<th>Findings (facilitators to return to work)</th>
<th>Findings (barriers to return to work)</th>
</tr>
</thead>
</table>
► Freedom to decide own work schedule.  
► Reduced physical labour.  
► The importance of work.  |                                                                 |
| 10. Lindbäck and Nordgren³⁸ (2014) | Qualitative study          | Sweden      | N=6; F=1; M=5; Heart failure=6; Age: 46–62 | Yes                                       | 3=working full-time or part-time at time of study. | ► Ability to work half-time.  
► Work adjustments.  | ► Responsible for rehabilitation process alone.  
► Abandonment by employers.  
► Difficulties with understanding and applying legislation.  
► Struggles to maintain self-image and identity.  |
| 11. Jbilou et al³⁸ (2019) | Qualitative study          | Canada      | N=93; M=93; CVD=93; (ACS=47); Age: 45–79 | Partially*                               | 17=RTW at time of study. | ► Reinforce self-confidence; overcome stress.  
► Sense of self as man in family and society.  | ► Not wanting to return to a stressful work. |
| 12. Wagner et al³¹ (2021) | Qualitative study          | Denmark     | N=32; F=8; M=25; OHCA=32; Age: 40–83 | Yes                                       | 17=RTW 3 months to 11 years post-diagnosis. | ► Return to normality.  
► Professional support.  
► Acceptance from colleagues.  | ► Physical and mental capacity and impairments.  |
| 13. O’Hagan (2019)²⁶ | Qualitative study          | Canada      | N=12; M=12; CVD=12; Age: 43–63 | Yes                                       | 12=had or were in the process of RTW at time of study. | ► RTW-programmes.  | ► Working conditions restrict conditions for work reintegration.  |
| 14. O’Hagan et al³⁸ (2012) | Qualitative study          | Canada      | N=12; M=12; CVD=12 (AMI=10); Age: 43–63 | Yes                                       | 12=had or were in the process of RTW at time of study. | ► Control over work demands.  
► Medical reassurance.  
► Occupational health department support.  
► Monitoring of CVD health at the worksite.  
► RTW-plans at the worksite.  | ► Worries about the effect of the work environment.  
► The design of the job.  
► Medical sanction for disability.  
► Cardiac rehabilitation with limited impact on RTW.  |
| 15. Salminen-Tuomaala et al³⁴ (2012) | Qualitative study          | Finland     | N=28; F=12; M=16; MI=28; Age: 32–82 | Partially*                               | Partially.*                 | ► A wish to work and to return to normality.  
► Breadwinner of the family.  
► Feelings of shame and guilt.  | ► Emotional exhaustion; no trust in ability to RTW.  
► Physical limitations.  
► No knowledge on when and how to resume normal life and physical activity.  |

*Partially: A mixed population where the proportion of working and non-working participants before and/or after diagnosis was not specified.

LVAD; left ventricular assist devices; ACS, acute coronary syndrome; AMI, acute myocardial infarction; CABG, coronary artery bypass graft; CVD, cardiovascular disease; F, female; M, male; MI, myocardial infarction; OHCA, out of hospital cardiac arrest; RTW, return to work.
3 studies reported on macro-level factors impacting on return to work. The identified barriers were categorised under four themes: physical limitations, psychological and relational factors, the working context and support within health and social care systems. The identified facilitators were categorised under five themes: return to normality, enhancing wellbeing, financial concerns, the working context and support within health and social care systems. The themes are visualised in figure 2.

Although barriers and facilitators are presented separately, it is important to acknowledge the complexity of each theme and the interplay between them. For example, as we will subsequently unfold, the working context both encompasses factors that hinder and facilitate return to work.

### Barriers to return to work

#### Physical limitations
- Fatigue
- Weakness
- General health status
- Comorbidities
- Medical restrictions
- Side-effects of medications

#### Psychological and relational factors
- Worries, fear, and insecurity
- Lack of motivation
- Mild cognitive impairment
- Struggles with maintaining identity
- Worried relatives

#### The working context
- Manual work
- Low job control
- High workload
- Limited possibility of work adaptions
- Unfavourable terms of employment
- Lack of support from colleagues and employers

#### Support within health and social care systems
- No assessment of work ability
- Lack of information on physical limits
- Insufficient focus on RTW in cardiac rehabilitation
- Difficulties with understanding complex legislation

### Facilitators to return to work

#### Return to normality
- A desire to return to everyday life and becoming meaningfully occupied
- Regaining purpose in life
- Male gender roles

#### Enhancing wellbeing
- Wanting a distraction from worries and to overcome stress
- Reinforce self-confidence
- Feeling good

#### Financial concerns
- Poor economic circumstances and the need of financial stability

#### The working context
- Workplace adjustments
- Flexibility
- Autonomy
- Working less
- Doing less strenuous tasks
- RTW-planning and support by occupational health staff
- Support from colleagues and employers

#### Support within health and social care systems
- Support from healthcare professionals
- Professional advice on how to approach the work situation

![Figure 2](https://example.com/figure2.png)

**Figure 2** Identified barriers and facilitators to return to work following cardiovascular disease. RTW, return to work.

12 studies reported on macro-level factors impacting on return to work. The identified barriers were categorised under four themes: physical limitations, psychological and relational factors, the working context and support within health and social care systems. The identified facilitators were categorised under five themes: return to normality, enhancing wellbeing, financial concerns, the working context and support within health and social care systems. The themes are visualised in figure 2. Although barriers and facilitators are presented separately, it is important to acknowledge the complexity of each theme and the interplay between them. For example, as we will subsequently unfold, the working context both encompasses factors that hinder and facilitate return to work.

**Barriers to return to work**

**Physical limitations**

Physical limitations were among the most frequent factors hindering return to work, reported by participants in 12 studies. Feeling physically impaired, tired, weak and experiencing long-term fatigue were reported to prevent participants from rejoining the workforce or reduce their capability to work. In addition, comorbidities, general health status, medical restrictions, as well as side effects of medication were listed as barriers to re-employment.

**Psychological and relational factors**

Internal challenges faced by participants in relation to return to work were reported in six studies. Worries, insecurity and lack of motivation were commonly reported barriers. Mild cognitive impairment and lack of mental resources, including concentration difficulties, short-term memory problems and feeling irritable were also mentioned as barriers, as these impairments impacted on participants’ work ability. In addition, fear of not fitting in at work, struggles with maintaining identity
and self-perception of work ability were barriers to re-em-
ployment in several studies.\textsuperscript{24} 29 31 38 Feelings of discour-
agement, fear of work-stress and even fear of death often
caused participants to re-appraise their lifestyle, making
them more interested in spending time with family than
working.\textsuperscript{33} 34 38 In a Turkish study, similar fears were
present among relatives and colleagues of participants,
who requested that the participants worked less or not at
all to take care of their health.\textsuperscript{34}

The working context

Manual work, limited possibility of workplace adaptations,
unfavourable terms of employment and lack of under-
standing and support from colleagues and employers
were some of the factors that discouraged participants to
return to work.\textsuperscript{25} 26 28 32 35 36 38 Among these factors, high
work demands and low control as well as restrictive con-
tions for work reintegration emerged as primary barriers.
For example, in two Canadian studies conducted among
men working at an auto-manufacturing plant, the partic-
pants reported how an intensive and high continuous
workload at the production line was the most significant
impediment to return to work.\textsuperscript{25} 26

Support within health and social care systems

Limited or no professional support from health profes-
sionals to assess work ability, insufficient focus on re-em-
ployment in cardiac rehabilitation and lack of knowledge
on the limits of one’s own physical condition were factors
identified by participants as hindering work resump-
tion.\textsuperscript{24} 25 31 34 36 38 In a Canadian study, participants described
that they did not benefit from participating in cardiac
rehabilitation, as it was of limited intensity, lacked spec-
ificity to work activities and focused on people of a higher
age.\textsuperscript{26} In a Swedish study, participants described how they
had difficulty understanding and applying complex legis-
lation and felt left alone with the responsibility of their
own rehabilitation process and management of their
illness.\textsuperscript{35} Besides relational support, participants in a
Dutch study expressed how public support, in terms of
social security rights, acted as a barrier to returning to
work, as it gave them the possibility of early retirement.\textsuperscript{35}

Facilitators to return to work

Return to normality

Returning to work was an important aspect of returning to
a meaningful life after CVD, and in seven studies a desire
to return to a normal everyday life and becoming mean-
fully occupied were factors identified as facilitators to
return to work.\textsuperscript{24} 26 27 29 31 32 37 For many participants re-em-
ployment marked a return to normality, where rejoining
the workforce meant resuming the life they had before
turning ill.\textsuperscript{24} 27 29 31 32 37 Several studies reported how
work was perceived as an integral part of life and iden-
tity and was an important means for regaining purpose
in life.\textsuperscript{24} 26 27 29 Male gender roles, such as identifying as
the breadwinner or the pillar of the family, were similarly
identified as facilitators of work resumption.\textsuperscript{24} 33 34 In a
Finnish study, a feeling of guilt and shame was explained
by male participants as a facilitating factor. These partici-
pants found it particularly difficult to stay at home as they
preferred working and participating in social life, wanting
to resume the life they had before they fell ill.\textsuperscript{33} Similarly,
in a Canadian study, male participants reported feeling
obliged to return to work due to a sense of masculinity
both within the family and in society at large.\textsuperscript{33}

Enhancing well-being

In several studies, participants expressed how returning to
work was a way of enhancing personal well-being.\textsuperscript{29} 32 33 35
For some participants work served as a distraction from
worries and gave a feeling of mastery\textsuperscript{29} 33 and self-
confidence.\textsuperscript{32} 33 For others, early return to work, even
against medical advice, was reported as a problem-solving
strategy to reinforce self-confidence and overcome
stress.\textsuperscript{33} Additionally, one Dutch study reported how
no physical complaints and feeling good after a cardiac
event also served as facilitators of re-employment.\textsuperscript{35} Lastly,
participants in a Singaporean study mentioned that a
greater awareness of left ventricular assist devices would
be beneficial for return to work, as it would reduce their
feeling of stigmatisation.\textsuperscript{32}

Financial concerns

Frequently mentioned motivators for return to work were
poor economic circumstances and the need for finan-
cial stability.\textsuperscript{29} 32 34 36 In a Turkish study, male participants
described that they had resumed work to financially
support themselves and dependent family members.\textsuperscript{34}
In a Danish study, participants additionally reported how
they would have preferred to stay at home, had it been
financially feasible.\textsuperscript{31}

The working context

It emerged from many of the included studies that
workplace accommodations, adjustments, flexibility and
autonomy acted as significant enablers for return to
work.\textsuperscript{26–29} 31 35 36 38 For some participants accommodations
such as working part-time, doing less strenuous tasks or
being able to control one’s own work schedule helped to
facilitate return to work.\textsuperscript{26} 29 36 38 Return-to-work planning
by occupational health staff at the workplace played an
equally important part. In example, seniority provisions
allowed some participants to change to positions with less
job strain or jobs with more control.\textsuperscript{30} In addition, support
from occupational health departments at the worksite,
as well as support and acceptance from colleagues and
employers were expressed by participants as encouraging
work resumption.\textsuperscript{25} 26 28 31 36

Support within health and social care systems

Within the health and social care systems, support from
professionals, guidance on managing acquired impair-
ments and specific assistance to reintegrate into the
workforce acted as facilitators.\textsuperscript{25} 27 31 32 33 Uncertainty
about returning to work was a concern for many partici-
pants,\textsuperscript{23–27} 35 36 and in a Norwegian study, professional

advice on how to approach the work situation, especially for those with manual work, served as a facilitator to return to work. Good supervision from health professionals equally gave participants the reassurance that they could manage re-employment.

DISCUSSION

This systematic review synthesised the qualitative evidence in relation to barriers and facilitators to return to work from the perspective of people living with CVD. By applying a comprehensive and robust methodology, a limited evidence base comprising 15 studies was revealed. Three of the studies applied a mixed-methods approach, where the quantitative evidence was diverse and limited. The included studies, which were of overall high quality and represented various settings and populations were synthesised through a qualitative meta-synthesis. Barriers were identified under four themes: physical limitations, psychological and relational factors, the working context and support within health and social care systems. Similarly, facilitators were identified under five themes: return to normality, enhancing well-being, financial concerns, the working context and support within health and social care systems. This review showed that returning to work following CVD is a complex process affected by multiple factors that may impact positively or negatively on re-employment. The identified barriers and facilitators to returning to work are interconnected and mirror components of contemporary biopsychosocial models of work disability, such as the Sherbrooke model. In line with this model, our findings show that the return-to-work process is influenced by personal factors (eg, physical, and psychological well-being), factors in the workplace system (eg, workplace adaptation and assessment of work ability), the health and social care system (eg, information and support) and the legislative and insurance system (eg, social security policies and regulations).

First, regarding personal factors, we found that well-being, motivation, self-perception and identity and the desire to return to normality were key factors impacting on return to work across most studies. For some individuals, returning to work meant resuming a meaningful occupation and returning to life as it was pre-CVD. In this case, and in line with previous research, work was perceived as an integral part of life and identity. For other individuals, the prospect of returning to work sparked fear and insecurity as they worried that they would not fit in at the workplace or would not be physically capable of performing their job. This is similar to the findings by Brannigan et al, who found that fear of failure to perform adequately at work serves as a barrier to returning to work for stroke survivors. Worries and insecurities related to re-employment emphasise the need to include psychosocial counselling as part of comprehensive cardiac rehabilitation programmes, which has also been suggested in recent reviews and meta-analyses. Another important barrier to work resumption was related to physical limitations, for example, long-term fatigue, weakness, comorbidity and general health status. Similarly, self-perceived health was a significant predictor of work status in one of the mixed-methods studies included in this review. These findings are supported by several quantitative studies showing that comorbidity is a predictor of no-return to work and demonstrate the need for reintegration strategies that focus on each individual’s disease and condition, as suggested in a recent systematic review and meta-analysis. These results are also in line with a recent Cochrane review that identified evidence showing that interventions combining exercise and psychosocial counselling components may increase the number of patients returning to work in the first 6 months after diagnosis and probably reduce the time away from work.

Second, our findings show that the workplace system encompasses both barriers and facilitators to returning to work. Facilitators included workplace adaptations, flexible working hours, assessment of work ability and understanding and acceptance from colleagues and employers. This illustrates the importance of involving the employer in making individualised return-to-work plans. Additionally, access to vocational rehabilitation programmes at the workplace played an important part, especially for participants with manual occupations. In line with these findings, a negative association between labour-intensive occupations and returning to work, was identified in one of the mixed-methods studies included in this review. Furthermore, Reibs et al highlights, in a review addressing determinants of reintegration of patients experiencing acute coronary syndrome, a need to pay special attention towards patients with physically demanding jobs and how stepwise reintegration is a supportive return-to-work strategy. Additionally, we found that acceptance and understanding from colleagues and employers are beneficial for work resumption, which corresponds well with other studies showing that social relations at the workplace are important for re-employment.

Third, regarding factors in the healthcare system, we found that people with CVD often express a need for information and support from healthcare professionals during their recovery. Supervision and assistance from healthcare professionals to reintegrate into the workforce served as facilitators. Furthermore, some participants felt left alone with the responsibility of their own rehabilitation with lack of professional support. They similarly described an insufficient focus on re-employment in cardiac rehabilitation programmes, which mirror previous research, indicating that vocational rehabilitation is not adequately implemented within cardiac rehabilitation programmes and that most European countries lack clear guidelines for vocational rehabilitation. However, other researchers have documented that cardiac rehabilitation programmes hold potential in improving return to work, and our findings illustrate the value of including vocational rehabilitation within cardiac rehabilitation efforts.
Fourth, this review shows how social security policies and regulations, including possibilities of withdrawal from paid employment, for example, for retirement, impact on participants’ decision to return to work. It should be acknowledged that people with CVD living in countries with poor social security policies are more likely to experience difficulties with returning to work. Furthermore, the need for financial stability and the potential loss of income served as a significant motivator for re-employment in many studies. This was especially found among men who often self-identified as the breadwinner of the family. This supports previous research showing that people with CVD often feel pressured to return to work due to financial reasons.19 Similarly, as described by Hegewald et al, delayed return to work can have negative financial consequences on individuals, especially when adequate financial support is not provided and this may be the main reason to decide if, and when, to return.9

Overall, this systematic review illustrates how multiple and diverse factors impact on the return-to-work process, and this knowledge should inform vocational rehabilitation programmes. There is a need for targeted interventions towards high-risk groups, namely those with high-disease burden, low socioeconomic status and high-work demands. The review further demonstrates the importance of ensuring individualised support and information as well as improving physical and psychosocial well-being within multidisciplinary and coordinated rehabilitation programmes, involving relevant stakeholders (eg, employers, healthcare professionals and social workers). To inform vocational support strategies, future studies could in more detail investigate patients’ information and support needs and explore the perspectives of relevant stakeholders. We also suggest that future studies investigate the impact of the duration of sickness absence. In the included studies information on sickness absence was not systematically reported, and therefore we could not explore the influence of duration of sickness absence on the nature of barriers and facilitators. In addition, as a large proportion of the included studies focused on individual characteristics and factors operating at the level of health and social care systems, the findings of this review are somewhat skewed towards micro and meso level factors. Therefore, more knowledge is needed on the importance of macro level factors, such as the potential impact of legislation and inflation on return to work.

Strengths and limitations

To our knowledge, this is the first systematic review of qualitative research into barriers and facilitators to return to work among people with CVD. A robust methodological approach was employed to identify and select studies relevant for inclusion, and included studies underwent thorough quality appraisal. Overall, studies were of high quality. The consistent and systematic approach of the meta-synthesis allowed us to synthesise findings, making them more accessible for healthcare professionals, organisations and policymakers.

Nevertheless, results should be appraised in the light of the methodological limitations. First, we included studies published between 2011 and 2022 to ensure studies are from the same period, reflecting more recent contextual issues of relevance for the experience of returning to work. We cannot exclude the possibility that this time frame has resulted in omission of relevant articles published before 2011. Second, the quality appraisal of the mixed-method studies could have been done using the mixed-method appraisal tool, which is recommended for appraisal of mixed-method studies.46 However, as this review only considered the qualitative components of the mixed-method studies, CASP was found appropriate. Third, the included studies were conducted in several countries. Hence, participants to some extent had different conditions for their return-to-work process, due to socio-political differences, including differences in pension systems and sick-leave legislation. On the other hand, this allowed us to achieve a deeper understanding of the diverse factors impacting on return to work. Fourth, in many of the included studies, return to work was not the primary focus. Many studies included mixed populations with both working and non-working individuals, and explored recovery from CVD more broadly, why some aspects of the return-to-work process still may need more exploration. In example, we suggest that the impact of macro-level structures shaping return to work, patients’ information and support needs, as well as how to successfully involve stakeholders in making effective return-to-work plans, are areas worth further in-depth explorations.

Lastly, it is relevant to consider the process of extracting information on experienced barriers and facilitators to return to work. Specifically, the differential impact of factors should be recognised. In example, returning to work was a means of coping with worries and insecurities for some participants, while these internal challenges kept others from returning to work. In addition, as factors are often inter-related, it is difficult to make a clear distinction between barriers and facilitators and to prioritise between single factors. Accordingly, barriers and facilitators should not be considered as isolated and independent entities. Rather, to offer direction for future research and interventions, the complexity and interdependency within factors and across levels are important to understand and acknowledge.

In conclusion, by identifying, appraising and synthesising the existing qualitative research on barriers and facilitators to return to work for people with CVD, this systematic review contributes to a better understanding of how to improve vocational rehabilitation efforts. People with CVD experience diverse barriers and facilitators associated with returning to work, and to address the hindering factors, early identification of individuals at risk of poor work reintegration is important. By attending to the individual’s physical and mental well-being, specific job characteristics and the surrounding context, social workers and healthcare professionals could be involved.
in this process. Vocational rehabilitation should be part of comprehensive cardiac rehabilitation programmes, and to improve return-to-work outcomes and the lives of people living with CVD, this review illustrates a need for ensuring individualised, multidisciplinary and coordinated vocational rehabilitation efforts that address potential barriers for re-employment experienced by the individual.

Contributors SMBJ, EBA and MK contributed to the study concept and design. SMBJ coordinated the project. EBA and SMBJ conducted the literature search, screened identified articles, performed data extraction and analysis. EBA drafted the first version of the manuscript. EBA and SMBJ drafted the second version of the manuscript. MK critically revised the manuscript. All authors have read and approved the final manuscript. All authors agreed to be accountable for all aspects of the work. SMBJ is responsible for the overall content as guarantor.

Funding This study is fully funded by The Danish Heart Foundation (grant number 99905). MK is partially funded by a grant from Nordøst-fonden (grant number 02-2013-0200).

Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement We have provided all data about all included studies, and the full search strings used in each database are available in online supplemental file B. Data are available on reasonable request. Data from the literature search and selection process are available on reasonable request to the corresponding author.

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