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Dutch occupational physicians and general practitioners wish to improve cooperation

Peter Buijs, Renée van Amstel, Frank van Dijk

Abstract
Objectives—To investigate cooperation between occupational physicians (OPs) and general practitioners (GPs).
Methods—Literature review; structured interviews; questionnaires sent to randomised samples of OPs (n=232) and GPs (n=243).
Results—Actual cooperation is poor. However, more than 80% of both groups responded that they want to improve their cooperation, aiming at better quality of care. Obstacles identified by OPs include insufficient knowledge among GPs about occupational health services (OHSs) (57%) and their patients’ working conditions (52%). OPs also consider that GPs suspect them of serving employers more than employees (44%) and of verifying reasons of absence with information from GPs (34%). Responses from GPs confirm these two suspicions (48%, response 58%), adding obstacles like commercialisation of OHS, lack of financial incentives, etc. Both groups are unanimous about prerequisites for improvement, especially guaranteeing the professional autonomy of OPs (OPs 86%, GPs 76%).
Conclusion—As a first step to overcome obstacles to cooperation, OPs must clarify their position to GP colleagues. Initiatives have been taken after presenting this study.
(Occup Environ Med 1999;56:709–713)

Keywords: occupational physician; general practitioner; sickness absence; occupational health services

Since 1998 each Dutch worker has had access to an occupational physician (OP), who has new tasks, related to sickness absence. Consequently, when employees become sick, both their OP and general practitioner (GP) must be involved. These groups of physicians have a long record of poor cooperation. Hopeful initiatives have been taken after presenting this study.¹ Since 1998 The Netherlands has been one of the first countries to achieve the goal set by the World Health Organisation (WHO) declaration of 1994 that Occupational Health Services (OHSs) should be available for all, whereas in 1994 only 45% of the six million Dutch workers had access to an OHS.² The reason was the combined need to implement the European framework directive (1989) and to cope with high rates and costs of sickness absence and disability. This resulted in many changes in legislation (1994): employers in small companies have to pay employees the first 2 weeks of sickness absence and in larger companies 6 weeks.³ Moreover, they became legally obliged to contract an OHS to assist them in guiding sick employees and preventing sickness absence by improving working conditions.⁴

Consequently, employees with health problems now have to deal with both their OP and GP; physicians with a long, intractable record of poor communication and cooperation, resulting in unnecessarily (long) sickness absence, lowered ability to work, and even permanent disability.⁵ ⁶

This cooperation problem originated a century ago, when European countries designed sickness absence legislation, all combined insurance for sick pay and the cost of health care.⁷ Only the Netherlands created two separate social systems.⁸ Treating physicians refused to verify or certify sickness absence, arguing that financial interests of patients would harm their confidential relation with them.

Certification may be troublesome for treating physicians outside The Netherlands.⁹ ¹¹ It also causes problems inside The Netherlands: Dutch GPs, having a central role in our health care, were not obliged to pay attention to their patients’ working conditions or to cooperate with OPs. Social security physicians and also about 50% of the OPs had to do the verifying or certifying, even though the International Labour Organisation (ILO) Convention (1985)¹² forbade OPs, on behalf of employers, from verifying the reasons for employees’ sickness absence. Our government, however, refused to sign. So the position of OPs remained unclear in the eyes of both GPs and employees. Consequently, when OPs request information, GPs fear legal action by patients for divulging confidential matters and strict rules for exchanging information are followed. These rules, however, have reduced cooperation to one sided requests for information.¹³

As sickness absence is a sensitive issue, this situation needed to be put right. Improvement of cooperation between OPs and GPs became a major goal, so that the medical associations could provide better health care, and the government could reduce sickness absence.¹⁴ The new legislation of 1994 was the first legislative attempt to give OPs new responsibilities without verification: to advise sick employees, to organise occupational rehabilitation, and advise about resuming work.

For workers with health problems, particularly complicated or chronic ones, adequate cooperation between OPs and GPs is an important prerequisite for good healthcare.
practice. Together, both physicians can complete their view on problems and their aetiology, and coordinate treatment and rehabilitation. That can help to prevent or shorten sickness absence and achieve optimal health. Combined with adapting working conditions, this will enhance the ability to work. Insufficient cooperation contributes to the opposite. We think that this applies in general to other countries too, despite differences in numbers, positions, and responsibilities of OPs and GPs, and in the rights, obligations, and prerequisites of society’s health care.

Maintaining the ability to work is increasingly important for workers themselves and national economies. But this is becoming more difficult, especially in Europe, because of aging (with more chronic diseases and handicaps) and increasing job demands. Lowered work ability and long term sickness absence is an economic burden. Rantanen estimates a global loss in gross domestic product (GDP) of 17%–30% because of occupational diseases, injuries, and loss of productivity. He argues that more investment in OHSs is better for workers and productivity.

Recent studies show growing attention to OHSs to reduce sickness absence in Europe. Long term absenteeism can lead to dismissal on grounds of work disability, Davidson warns. “Employees, absent from work for reasons attributed to ill health often involve an OP,” he continues, concluding, “Communication with others involved in clinical care, if appropriate, is also wise. Neither patient nor treating doctor may realise that a condition is work related.” Recent research among NHS employees confirms the importance of communication between OPs and other doctors involved in sickness absence.

In this sense we think that OHSs can have a considerable intermediary role in an increasingly important field, where health care, labour, and social security meet.

Methods
To obtain a more factual basis for improvement, in 1995 the Ministry of Health commissioned the Dutch Institute of Working Conditions, NIA TNO (since 1-1-1999 TNO Work and Employment), to study cooperation between OPs and GPs. The major research questions were: (a) to describe the level of cooperation; (b) to investigate if the recent changes in legislation improved cooperation; (c) to examine whether both groups of physicians desire improvement; (d) to explore what, precisely, should be improved; (e) to identify obstacles and prerequisites for improved cooperation.

After a review of the literature and interviewing 25 OPs, GPs, medical specialists, and others with specific knowledge of cooperation, two questionnaires were developed. These were tested for content, face validity, and acceptance by the interviewees. Data gathered included personal details, details of professional practice, and occupational and regional background. Also information was gathered about frequency and reasons for contact between OPs and GPs, experiences of exchanging medical information, and of verifying activities. Finally opinions were sought about advantages, obstacles, wishes, and prerequisites for improvement.

Our database for the GP sample was the information system of the Royal Dutch Medical Association KNMG, containing data of all GPs (in 1995 n=6753). For the OP sample the best database available was the list of members of the OPs’ Association NVAB (in 1995 n=1183 members), which traditionally represents almost all OPs. However, since the OHS market was commercialised in 1994, which attracted new OHS organisations, this may not be the case. Additional samples were taken from the two largest, countrywide, new OHS organisations. Random samples were taken in the strata of each group.

Questionnaires were sent to 405 OPs and 599 GPs. The response rates were 61% and 42% respectively. Comparisons were made for age, sex, and type of practice with the national GP sample, the GP response group showed no great differences. In the OP response group, all types of OHSs were represented, with reasonable dispersal over the country. No indications were found suggesting selection bias. Next, two study groups, consisting of 232 OPs and 243 GPs respectively, were formed. The results from GPs could be adapted to national levels by statistical weighting, as the composition of the total population of GPs is known. The outcome of the study group of GPs is presented in percentages based on weighted data. For the study group of OPs this was impossible, because the number and composition of the OP population is unknown. As in the GP group, however, there was almost no relation between OP answers and the characteristics age, sex, region, and type of practice. So the results for the OPs are a good indication of what would be expected from the total population of OPs.

Results
ACTUAL COOPERATION
As there are about four times more GPs than OPs, half of the responding GPs reported one or less contact a month with an OP; 22% reported weekly contact, mostly by telephone. According to the GPs, OPs initiated 85% of contacts, mostly asking for information. The OPs report more mutual contact—for example, to plan joint treatment strategies, but GP responses do not reflect this kind of contact (table 1). The GPs are cautious, guarding the interest of their patients and themselves against possible legal action. Generally, both disciplines report that they respect the strict rules about exchanging information.

Table 1  Reasons given (%) by occupational physicians (OPs) and general practitioners (GPs) for occupational physicians to contact general practitioners

<table>
<thead>
<tr>
<th></th>
<th>OPs (%=232)</th>
<th>GPs (%=243)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To get information about employees’ complaints</td>
<td>54</td>
<td>67</td>
</tr>
<tr>
<td>To plan a joint strategy for treatment and rehabilitation</td>
<td>44</td>
<td>14</td>
</tr>
<tr>
<td>To receive therapeutic information</td>
<td>33</td>
<td>37</td>
</tr>
<tr>
<td>To inform GPs about their patients’ working conditions</td>
<td>32</td>
<td>13</td>
</tr>
<tr>
<td>To ask for prognosis about work incapacity</td>
<td>18</td>
<td>29</td>
</tr>
</tbody>
</table>

References. In the OP response group, all
Table 2  Advantages given by occupational physicians (OPs) and general practitioners (GPs) for better cooperation

<table>
<thead>
<tr>
<th>Advantage</th>
<th>OPs (n=232) (%)</th>
<th>GPs (n=243) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More complete insight about the patient's situation</td>
<td>81</td>
<td>57</td>
</tr>
<tr>
<td>Better rehabilitation</td>
<td>80</td>
<td>64</td>
</tr>
<tr>
<td>Prevention of contradictory advice</td>
<td>79</td>
<td>71</td>
</tr>
<tr>
<td>Better coordination</td>
<td>75</td>
<td>68</td>
</tr>
<tr>
<td>Less chance of being absent through ill health</td>
<td>73</td>
<td>56</td>
</tr>
<tr>
<td>Patients cannot play professionals off each other</td>
<td>36</td>
<td>54</td>
</tr>
<tr>
<td>Reducing sickness absence</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Better management of sickness leave</td>
<td>7</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 3  Important obstacles to cooperation mentioned by occupational physicians (OPs)

<table>
<thead>
<tr>
<th>Obstacle</th>
<th>OPs (n=232) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 GPs lack knowledge of occupational health services and relevant legislation</td>
<td>57</td>
</tr>
<tr>
<td>2 GPs do not understand what they can expect from OPs</td>
<td>54</td>
</tr>
<tr>
<td>3 GPs do not take into account their patients' jobs</td>
<td>52</td>
</tr>
<tr>
<td>4 GPs do not realise that unnecessary sickness leave can harm patients</td>
<td>49</td>
</tr>
<tr>
<td>5 GPs think that OPs serve employers more than employees</td>
<td>44</td>
</tr>
<tr>
<td>6 GPs are difficult to reach by telephone</td>
<td>40</td>
</tr>
<tr>
<td>7 No guidelines about cooperation available</td>
<td>37</td>
</tr>
</tbody>
</table>

Table 4  Important obstacles to cooperation mentioned by general practitioners (GPs)

<table>
<thead>
<tr>
<th>Obstacle</th>
<th>GPs (n=243) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 GPs do not know for what purpose OPs will use information from GPs</td>
<td>58</td>
</tr>
<tr>
<td>2 GPs think that OPs serve employers more than employees</td>
<td>48</td>
</tr>
<tr>
<td>3 GPs do not understand what they can expect from OPs</td>
<td>39</td>
</tr>
<tr>
<td>4 Commercialisation of occupational health services</td>
<td>37</td>
</tr>
<tr>
<td>5 Time spent on cooperation is not financially compensated</td>
<td>36</td>
</tr>
<tr>
<td>6 GPs must be cautious in supplying information to OPs, not knowing where it will end up</td>
<td>35</td>
</tr>
<tr>
<td>7 GPs lack knowledge of occupational health services and relevant legislation</td>
<td>34</td>
</tr>
</tbody>
</table>

Table 5  Opinions of occupational physicians (OPs) and general practitioners (GPs) on referrals by OPs to medical specialists

<table>
<thead>
<tr>
<th>Reason</th>
<th>OPs (n=232) (%)</th>
<th>GPs (n=243) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For diagnostic reasons:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No objection</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>Only after consulting with GP</td>
<td>40</td>
<td>23</td>
</tr>
<tr>
<td>Only on special occasions</td>
<td>25</td>
<td>13</td>
</tr>
<tr>
<td>Absolutely against</td>
<td>6</td>
<td>59</td>
</tr>
<tr>
<td>No opinion</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>For treatment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No objection</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Only after consulting with GP</td>
<td>61</td>
<td>17</td>
</tr>
<tr>
<td>Only on special occasions</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>Only when employers pay</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>Absolutely against</td>
<td>10</td>
<td>75</td>
</tr>
</tbody>
</table>

Only 38% of the GPs considered their relations with OPs as good, about the same as those with social workers and psychologists, but below relations with medical specialists or physiotherapists (both 62%). Only relations with social insurance physicians scored lower: 14%.

Obstacles and Prerequisites
Both groups could identify 14 obstacles to better cooperation (10 were the same in both groups) as important or unimportant. Tables 3 (OPs) and 4 (GPs) present seven obstacles mentioned as most important. Almost all obstacles stated by the OPs were related to GPs, whereas most GP obstacles were related to OPs or their services. Only three were common to both groups, among them the OP’s main obstacle: GPs lack of OHS knowledge. For GPs the main obstacle was that OPs do not clarify why they request information from GPs. It is interesting that 71% of the OPs report they always clarify the reason for information. When the GPs were asked if they had negative experiences on this point, only 13% answered yes, 60% no.

The privatisation in 1994 allowed OPs to refer directly to medical specialists, often to get a rapid cure. Because sick employees cost employers money, GPs feared that OPs would be pressurized to bypass them, allegedly undermining the gatekeeper position of GPs in health care, causing a two tier system.24 Table 5 shows the diverging opinions of the two groups.
Table 6 shows the 10 prerequisites (from an original list of 13) mentioned as most important. In both groups the top three have high percentages, the OPs reflecting two high GP priorities. The next five prerequisites were mentioned by about two thirds of both study groups.

Factor analysis shows for both study groups a cluster of fundamental prerequisites: protection of the workers’ health; using common concepts; better information about what OPs really can do; care in use of information from GPs.

The GP group shows some significant differences ($\chi^2 p<0.05$): women more than men want clarity about what OPs really can do; older rather than younger GPs underline the importance of professional autonomy of OPs, and GPs with little contact with OPs want more opportunities to meet them and clarify why OPs ask for information.

Discussion and conclusions

The research questions can now be answered as follows:

COOPERATION BETWEEN OPs AND GPs IS LOW AND ONE SIDED: OPs MAKE CONTACT, MOSTLY TO GET INFORMATION

This confirms earlier research that illustrates the long history of poor cooperation and non-action. Contact being initiated by OPs to plan joint strategy or to inform GPs about the working conditions of their patients is new; but only a few GPs concur. And although most OPs say that they always clarify why they ask for information, GPs consider that OPs lack of clarity on that point as the major obstacle, although only some GPs report negative experiences.

CHANGES IN LEGISLATION, MEANT TO IMPROVE COOPERATION, FAILED TO DO SO

This could be a serious threat. If paying sick employees during the first 2–6 weeks by their employers already has predominantly negative effects on cooperation between OPs and GPs, how will the recent extension (in 1996) to 52 weeks work out? Negative consequences for the professional autonomy of OPs, preventive activities, and contacts with treating physicians have already been reported, and next to the exclusion from work of people with (assumed) health problems, is the main reason why all medical associations had strongly opposed this new law.

BOTH GROUPS OF PHYSICIANS WANT IMPROVEMENT

The high percentages in favour of improved cooperation surprised the professional organisations of the OPs and GPs, as did the advantages of more coordination, rehabilitation, and insight into the patients’ situation, less contradictory advice, or chance of having sickness absence. This supported their policy aimed at better cooperation to improve the quality of care. As the figures show, quality of care seems to be a more effective way of appealing to physicians than simply challenging them with reducing sickness absence.

BOTH DISCIPLINES HAVE THEIR OWN PRIORITIES FOR IMPROVEMENT

The OPs may think that improvement is just a matter of GPs being more accessible and informed about OHS matters, and the GPs think that the OPs should first clarify their own position and intentions, especially relative to verification of absence. That makes sense: although OPs are no longer obliged to verify the cause of sickness absence, almost all report that they do, instead of about 50% before 1994. This development is contrary to what our organisation for OPs wants, the ILO prescribed, and the Dutch legislation of 1994 intended. (In 1995 our government tried to reintroduce verification by OPs, which the medical organisations successfully opposed. The minister had to admit that OPs can only do their job properly if they have a confidential relation with employees, which is incompatible with verification activities.)

Most OPs, however, consider verification not as verifying the medical reasons for absence but as assessing the balance between workload and capacities, or supporting return to work. The GPs probably do not consider these activities as verifying, and consequently this is an obstacle to cooperation. Clarity in practice and terminology is required, as is clarity about the official task of GPs to advise patients about work resumption, without ascertaining cause of sickness absence. Only some GPs do this regularly.

AGREEMENT ABOUT MAIN PREREQUISITES, LESS ABOUT OBSTACLES

The OPs regard obstacles to better cooperation mostly as related to GPs. The GPs see things the other way round, especially about possible use of information they provide. Apparently, it is easier to attribute obstacles to others than to accept one’s own contribution to the impasse. However, both groups of physicians agree with the views of some sceptical or even suspicious GPs: that GPs think that OPs serve employers mostly as related to GPs. The OPs may think that improvement is just a matter of GPs being more accessible and informed about OHS matters, and the GPs think that the OPs should first clarify their own position and intentions, especially relative to verification of absence. That makes sense: although OPs are no longer obliged to verify the cause of sickness absence, almost all report that they do, instead of about 50% before 1994. This development is contrary to what our organisation for OPs wants, the ILO prescribed, and the Dutch legislation of 1994 intended. (In 1995 our government tried to reintroduce verification by OPs, which the medical organisations successfully opposed. The minister had to admit that OPs can only do their job properly if they have a confidential relation with employees, which is incompatible with verification activities.)

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Cooperation between Dutch occupational physicians and general practitioners

issue has caused much trouble between the two medical organisations.

So clarification of the ambiguous position of OPs is urgent. The consensus about the prerequisites, all regarding main obstacles, offers a useful profile of OPs: professionally autonomous; commitment to the employees’ health; clarifying what they can do for patients; care with use of information from GPs. In short they should be independent specialists in occupational medicine, as are OPs outside The Netherlands.27

The GPs also have work to do: clarifying their position on sickness absence, especially on advising about resumption of work; improving their knowledge about OHS; relevant legislation; and their patients’ working conditions. Together, OPs and GPs must develop common concepts and guidelines for cooperation, and stimulate familiarity and mutual trust. Finally, financial compensation for time spent on cooperation will probably help.

RECENT DEVELOPMENTS

Considering the long history of non-action, much progress has been made since the research report was presented to the Ministers of Health and Labour, and the chairmen of the professional organisations of OPs and GPs in February 1997. Encouraged by their members’ strong wish for improvement, combined with the unanimous supported prerequisites, both organisations have stopped their dispute. Instead, based on the recommendations from the report, they have agreed to cooperate; to develop specific education programmes, common guidelines, and local experiments; to facilitate exchange of information; and to reach consensus about tasks, position, and responsibilities of both physicians for cooperation, including the issue of referral. That consensus was reached and presented to the Minister of Health in 1998.28 This process was facilitated by a professional charter (NVAB, 1997), intended to guarantee autonomy for OPs. This charter, which also rejected verification tasks, was accepted by the branch organisation of the medical organisations.

Meanwhile, implementation of the rest of the agreement has started, and our institute was welcomed and supported by a professional charter (NVAB, 1997), including the issue of referral. That consensus about tasks, position, and responsibilities of both physicians for cooperation, including the issue of referral, was reached and presented to the Minister of Health and Labour, and the chairmen of the professional organisations of OPs and GPs in February 1997. Encouraged by their members’ strong wish for improvement, combined with the unanimous supported prerequisites, both organisations have stopped their dispute. Instead, based on the recommendations from the report, they have agreed to cooperate; to develop specific education programmes, common guidelines, and local experiments; to facilitate exchange of information; and to reach consensus about tasks, position, and responsibilities of both physicians for cooperation, including the issue of referral. That consensus was reached and presented to the Minister of Health.28 This process was facilitated by a professional charter (NVAB, 1997), intended to guarantee autonomy for OPs. This charter, which also rejected verification tasks, was accepted by the branch organisation of the medical organisations. Meanwhile, implementation of the rest of the agreement has started, and our institute was welcomed and supported by a professional charter (NVAB, 1997), including the issue of referral. That consensus about tasks, position, and responsibilities of both physicians for cooperation, including the issue of referral, was reached and presented to the Minister of Health.28 This process was facilitated by a professional charter (NVAB, 1997), intended to guarantee autonomy for OPs. This charter, which also rejected verification tasks, was accepted by the branch organisation of the medical organisations.

We thank Malcolm Harrington, Stuart Whitaker, and especially Max Brecher for their critical comments.


5 Bujs PC. Curatieve gezondheidszorg, ziekteterreur en arbeidsongeschiktheid (Curative care, sickness absence, and disability); [thesis]. Amsterdam: Amsterdam University, 1984.


