Managing Work-Related Psychological Complaints by General Practitioners, in Coordination with Occupational Physicians: A Pilot Study —Developing and Testing a Guideline—^a

Peter C. BUIJS^{1*}, Frank J.H. van DIJK³, Marjé EVERS¹,
Jacques J.L. vd KLINK⁴ and Han ANEMA²

¹ Toegepast Natuurwetenschappelijk Onderzoek: Applied Scientific Research, Work and Employment, Hoofddorp, The Netherlands

² Current affiliation VU University Medical Centre, Amsterdam, The Netherlands

³ Coronel Institute of Occupational Health, Academic Medical Centre, University of Amsterdam, The Netherlands

⁴ Netherlands School of Public and Occupational Health, Amsterdam, The Netherlands

Received August 15, 2006 and accepted November 2, 2006

Abstract: Increasingly, workers have psychological work-related complaints, endangering their work ability and causing considerable economic losses. Many employees consult their general practitioner (GP). He, however, often pays insufficient attention to work-relatedness or to coordination with occupational physicians (OPs). Appropriate guidelines are missing. Consequently, we developed a GP guideline to handle these problems in coordination with OPs, and tested it in a pilot, using an explorative, evaluative study design. 23 GPs were trained to include employed patients and to test the guideline. Patients received questionnaires after 0, 4, 10 and 30 wk, GPs after 4 and 30 wk. The result was a new guideline, regarding problem orientation, diagnosis and advice, meant to avoid contradictory GP-OP advice and to activate patient responsibility. It included a GP-OP-patient communication form concerning information exchange and harmonization of insight/advice. Implementing GPs concluded that the guideline promotes recovery and work resumption and OP-GP contact benefits patients, prevents conflicting advice and promotes agreement on task division. They judged guideline efficiency and OP commitment less positively. Patients were positive, especially about GP-OP contact. Accordingly, an improved guideline, when tested for its effectiveness in a Randomized Controlled Trial, can help GPs to cope with a growing, complex problem, in collaboration with their occupational colleagues.

Key words: Occupational physician, Occupational health, Psychological complaints, Work-related, Guideline, General practitioner, Coordination

Introduction

“We have a global stress epidemic”, ICOH-president Rantanen stated¹⁾. And indeed, many employees suffer from

burnout, overstrain and other psychological, often work-related complaints^{2,3)}, which endanger their work ability. In the UK mild mental disorders cause almost 40% of sick leave⁴⁾ with an estimated annual loss of 40 million workdays⁵⁾. The ILO estimates the annual cost of work absence and productivity loss in the USA due to job stress about \$200 billion⁶⁾. Mental disorders occur in about one-third of Dutch employees with

^aPresented at the 13th International Congress on Occupational Health Services, November 30 – December 3, 2005, Utsunomiya, Japan.

*To whom correspondence should be addressed.

long-term sick leave or work incapacity benefits²⁾.

In Japan, the ratio of workers feeling stress, being troubled and feeling strong anxiety caused by work life increased from about 50% in 1982 to 61.5% in 2002. Important causes of stress are negative human relations at the work place, too much workload, a lack of work quality, employment instability and insufficient aptitude for the job. The number of mental disorders increased from 1999 to 2003 both in applications and certifications regarding occupational diseases⁷⁾.

Managing those and other work-related diseases is core business for occupational physicians (OPs). However, only a few countries have sufficient occupational health coverage (e.g. The Netherlands, Finland, France, Belgium, Slovenia¹⁾, so many workers have to visit their general practitioner (GP). In the UK one-third of GP consultations have a substantial mental health component, dealt with for 90% within primary care⁸⁾. And although almost all Dutch employees have free access to an OP, they prefer their GP, also before reporting sick. Andrea followed 12,000 employees before sick leave. In six months 35% of them visited their GP, 13% of whom for psychological reasons. Only 3% visited their OP, 29% of whom for purely mental problems. When employees suspected somatic reasons, they preferred their GP⁹⁾.

However, GPs often neglect work-relatedness of complaints, miss relevant expertise and seldom contact OPs, who mostly get involved after some weeks sick leave¹⁰⁾: 43% of 555 Dutch employees with work-related mental complaints consulted their GP two months before sick leave, against 11% who consulted their OP. Only 26% of the GPs asked about working conditions while 78% of the OPs did. After four weeks of sick leave, consultation percentages were 74% and 69% respectively, 36% of the GPs asked about working conditions, 55% of the OPs. GP-OP contacts were rare¹¹⁾.

Insufficient GP attention to work-related health problems and to coordination with OPs has been known for decades¹²⁾. This 'Blind Spot' is usually explained by the fact that Dutch GPs, unlike colleagues abroad, do not certify sickness absence and therefore are not obliged to explore 'work components' of health complaints¹³⁾. Research showing that 83% of Dutch OPs and GPs want improvements¹⁰⁾ caused many initiatives: regional and national GP-OP meetings, regular OP-GP board consultations, regional experiments, development of protocols and guidelines and OP-GP continuous medical education modules¹⁴⁾.

Yet, in spite of presumptive evidence of efficacy and cost-effectiveness of GP¹⁵⁾ and OP³⁾ interventions, GP guidelines to handle work-related psychological problems, coordinated

with OPs, were still lacking, even at the Dutch GP Society, internationally famous for its numerous guidelines.

Materials and Methods

Against this background NWO (Dutch Organization for Scientific Research¹⁶⁾ asked us to develop a GP guideline, including coordination with OPs, to identify performance indicators to measure quality and effectiveness, and to evaluate the feasibility in a pilot study. After briefly describing the first aspects, we will concentrate on the evaluation¹⁷⁾.

We have based the new guideline on parts of a recent OP guideline on work-related psychological complaints¹⁸⁾ and on a general cooperation guideline, recently developed for the two medical associations involved, providing criteria for GP-OP contact¹⁹⁾. The guideline consists of five steps (Table 1), aiming at GP-OP consensus about mutual responsibilities and tasks, and at avoiding contradictory advice to patients. An important part is a GP-OP communication form, designed to activate patient responsibility: he or she must reach consensus with the GP about the problem approach, sign the form and take it to their OP¹⁹⁾.

Performance indicators derived from the cooperation guideline are in accordance with results of other studies²⁵⁾ (Table 2). When criteria, mostly following an 'if-then' logic, were not met, they were assigned 'one' (1). If all applicable criteria for an indicator were met, the total score was zero (0). For each indicator, which had been assessed independently by the researchers, a performance rate was calculated.

Design of the pilot study

Inclusion criteria to be applied by the GPs were that patients were sick-listed, were able to read Dutch, had paid work and psychological or stress-related physical work-related complaints. Exclusion criteria for the GPs were depression, anxiety or other psychiatric disorders, somatic diseases accounting for the complaints, GP-patient distrust and disagreement on diagnosis.

GPs were asked to evaluate the guideline's outcome, process and effectiveness twice. They completed a checklist at each patient consultation and a questionnaire after 4 and 30 wk. Patients completed a questionnaire at the start and 4, 10 and 30 wk after inclusion, regarding their satisfaction about the guideline's outcome, their GP's medical management and GP-OP contact. Process measures were GP's use of and satisfaction with the guideline, and indicators

Table 1. GP Guideline for managing work-related psychological complaints, incooperation with OPs: five steps

Steps	
Problem orientation	Ask patient about work, date of sick leave, work-relatedness of complaints, workload, stressful factors at home, coping/problem solving strategies, support from OP/others, patient's point of view; obstacles to resume work.
Diagnosis	Why does this patient develop these complaints on this moment? Classify complaints: work-related psychological disorder, overstrain, burn-out.
Exchange of information or referral	When there is e.g. insufficient information for adequate treatment: Consult the OP by communication form and/or refer the patient.
Harmonization of insight	If work-related mental problems require OP attention, if there are obstacles to resume work or if an intervention at work is needed, consult the OP by the communication form.
Harmonization of advice	If the GP-advice can hinder work resumption, is contrary to the OP advice or if the GP wants to advise patients with work-related problems, consult the OP by the communication form.

related to GP care: problem clarification, information exchange, harmonization of insight and advice, informed consent and results. GP-OP contact was regarded as the guideline's output. Finally, guideline effects perceived by GPs were described in terms of patient satisfaction, GP work process and effectiveness on recovery, and return to work.

GP questionnaire topics included diagnosis and prognosis of sick leave and return to work, outcome and satisfaction of GP-OP contact, and finally process and outcome evaluation (guideline implementation, effectiveness on durability and rapidity of recovery and return-to-work determinants of the guideline's implementation).

Patient questionnaire topics were return-to-work expectancy, burnout (measured by Maslach Burnout Inventory, Dutch version: Utrechtse BurnOut Scale (UBOS) 2000), fatigue (measured by the Checklist Individual Strength (CIS) 2003), satisfaction with GP's skills, knowledge, attitude, independence, confidentiality, trust, GP-OP communication, GP-OP contact, perceived effect on return to work, working conditions and treatment.

Results

After approval of the study design by the TNO Ethics Committee, and after presenting our project on a combined OP-GP continuous medical education meeting, 15 GPs agreed to test the guideline. Ten others were recruited by networking and advertising.

Finally, 23 GPs were trained in guideline use. 12 of them included 24 patients. Of these 12, 11 had been a GP for more than five years. All patients agreed to participate. Table 3 shows their characteristics. Descriptive statistical analyses were done to analyze the results.

GPs followed the guideline *entirely* with ten patients, *partly* with another ten patients and not at all with four patients. GPs using the guideline partly or not at all mainly hold OPs responsible for not answering or being unreachable. Sometimes GPs did not use the entire guideline because patients did not revisit them or refused to see the OP.

Factors which GPs considered to facilitate guideline implementation were: GP and patient expectation towards effectiveness of the protocol; compliance with the protocol; positive balance between GP time investment and rewards for patients; the OP-GP communication form brought over by the patient. Some factors, such as patient trust in their OP, were sometimes considered as hindering, sometimes as facilitating. GPs considered as main hindering factors time investment and lack of trust in OPs.

Overall, GPs were moderately satisfied with the guideline (mean satisfaction score 5.5 on a 1–10 scale). Three GPs considered it as too time consuming and three others found the OP role too limited. GPs met the performance indicators, except at the item 'results of OP contact' (Table 4).

Work resumption and contact with OPs

For the ten patients GPs following the guideline entirely,

Table 2. Performance indicators and criteria for effective GP management of work-related psychological problems

Performance indicators	Criteria leading to a positive or negative score
1. Problem orientation	GP asks: <ul style="list-style-type: none"> - Do you have paid work? If yes, which profession? - Are you absent from work? If yes, since when? Answer is yes: <ul style="list-style-type: none"> - Are medical symptoms caused or aggravated by work? - Are there obstacles for return-to-work or functioning at work? - Did the patient contact an OP? If yes, what was the advice?
2. Need to exchange medical information with or refer to the OP	Insufficient information for adequate care (diagnosis, therapy) or concerning work-relatedness.
3. Need for OP consultation/harmonization of insight	There are medical problems that need OP attention, and/or there are obstacles for return-to-work or functioning at work, and/or workplace intervention is needed.
4. Need for OP consultation or harmonization of advice	When GP advice conflicts with OP advice, and/or When GP considers the problem as work-related, and/or When GP advice can be an obstacle for return-to-work.
5. Adequate outcome/result of consultation or harmonization	When there is GP-OP consensus about mutual tasks and responsibilities and no conflicting advice.

seven times GPs reported positive effects on work resumption durability and six times on work resumption rapidity, against only two times if the guideline was followed partly. One GP considered the guideline counteracting. Effects of following the guideline on recovery were quite similar to those on work resumption. GPs used the communication form 29 times, concerning 17 patients. For six patients they saw no reason to use it, one patient refused. 18 GP-OP contacts concerning 12 patients were reported of which 13 for information exchange and harmonization of insight or advice and once for referral; 11 times contact provided GPs with sufficient information. Three times contact prevented conflicting advice regarding treatment, while in eight cases they had the same opinion prior to contact. Seven times the result was unknown.

On reintegration contact with OPs prevented conflicting advice six times, five times there was already agreement and seven times effects were unknown.

On task division GPs agreed 14 times with OPs or did not discuss it, while only once they disagreed. 11 out of 18 times GPs found that contact with OPs benefited the patient, four times it did not. Two GPs changed treatment after OP

contact. At 14 occasions GPs considered contact as time consuming.

Patient satisfaction

The patients were satisfied with their GP's attitude, professionalism, expertise, trust, communication and confidentiality (overall mark 8.7 on a 1–10 scale), appreciating the GP contribution more than the OP contribution. Patients were extra satisfied (9.0 versus 8.4) when the GP contacted the OP, although they reported no positive effects on treatment, work resumption or working conditions.

According to the UBOS scale, six patients suffered burnout at the start (inclusion) and two after 30 wk. The mean CIS score on fatigue was 96 at inclusion, and 70 after 30 weeks - a value between the 80th and 90th percentile, still high compared to healthy people. At inclusion 20 patients were on sick leave. After 30 weeks six had resumed work completely, three partially, ten had not, while for one patient it was unclear.

Table 3. Baseline patient characteristics (n=24)

GP diagnosis	8 stress-related 10 nervous exhaustion 3 burnout 3 other diagnosis
Age, mean (st. dev.)	43 (11.0) years
Sex	7 men, 17 women
Work disability or work status	20 sick leave 2 partial work resumption 2 unknown
Type of job	7 blue collar 10 white collar 7 unknown
Burnout (UBOS)*	
% Burnout patients:	26% (44.9%)
Mean (st. dev.) on:	Emotional exhaustion: 3.25 (1.54) Distance: 2.41 (1.15) Competence: 3.84 (1.12)
CIS (Checklist Individual Strength)**	
Mean (st. dev.)	96.20 (23.75)

*Burnout is diagnosed, when scores on emotional exhaustion are in the highest 25%, and when scores on distance are in the highest 25% and/or on competence in the lowest 25%.

**Maximum CIS-score: 133.

Table 4. Extent to which GPs followed the guideline on various aspects

Performance Indicators (PI's)	% criteria met
1. Problem orientation	78%
2. Exchange of information	100%
3. Harmonization of insight	79%
4. Harmonization of advice	89%
5. Results	57%
6. Informed consent	88%

Nrs. 1–5 follow the PI's mentioned in Table 2, PI 6 has been added here.

Discussion

Main results

A new GP guideline has been introduced for managing work-related psychological complaints, in cooperation with OPs, activating patient responsibility. The GPs implementing this guideline concluded that it was time consuming, but promoted recovery and work resumption, while OP-GP contact prevented conflicting advice and mostly benefited patients. Mostly GPs agreed with OPs on task division.

Overall GPs were moderately satisfied, although OP commitment should improve. Patients were very positive, especially when GP-OP contact was established, although no effects on work outcomes were reported.

Strengths and limitations

To our knowledge no similar guideline, including OP-GP cooperation, had been developed and tested in practice earlier. We focused on GPs, because many employees consult them first, although their expertise, attention to work-relatedness and OP contacts often are insufficient¹⁰.

The implementing GPs reported several positive effects, for instance regarding the communication form, activating patient responsibility and offering a practical solution for establishing GP-OP contact. Finding 'GP volunteers' was harder than expected, presumably due to heavy workload, GP shortage, research tiredness or doubts about OP independence. This problem is known abroad as well, where OPs manage sick leave and are sometimes even nicknamed "Sickness absence police"²⁰. In our study patient-OP mistrust hindered guideline implementation.

Patient inclusion was unexpectedly difficult too. When the researchers, both physicians, reminded GPs twice by phone, their excuse mostly was 'I forgot; too busy; difficult to fit into daily routine' - internationally well-known problems²¹. This may have caused selection bias: participation of motivated GPs and patients. Because of that and the limited amount of GPs and patients results cannot be considered as representative and can only be generalized cautiously.

Comparison with other studies

Patient satisfaction about GP-OP contact, an important guideline goal, is remarkable, because no positive effects on treatment, working conditions or work resumption have been reported. The relation between patient satisfaction and guideline compliance can show contradictory results, as has been reported in other studies on work-related psychological complaints and GP-OP contact:

- Hulshof *et al.* evaluated an experimental guideline on cooperation in cases of mental health problems, including 20 GPs, 12 OPs and 121 patients. Better doctor performance resulted in fewer health complaints and less patient satisfaction. Like in our study, patients valued GPs higher than OPs (8.2 against 6.9), GPs considered the guideline as complex and time consuming and OPs as insufficiently committed and difficult to reach. OPs considered GPs difficult to contact²².

- Venema *et al.* analysed 1100 patients, 83 OPs and 58 GPs. Mostly no GP-OP contact occurred when indicated, but patient satisfaction was high with both GPs and OPs²³
- Anema *et al.* studied 100 patients with work-related psychological complaints. They were satisfied about OP contact, also when OPs deviated from their guideline²⁴. Satisfaction increased when OPs followed the guideline and made a 'problem orientation', using GP information.
- Nieuwenhuijsen showed the opposite: the stricter OPs followed the guideline on mental complaints, the less patient satisfaction was established, but sickness absence decreased nevertheless²⁵.
- Huibers trained GPs in cognitive therapy for long-term fatigue. GPs and patients assessed treatment positively, although effects failed²⁶.

Finally, GPs would like more OP commitment. Other research shows however, that OPs initiate 80-90% of the GP-OP contacts¹⁰.

Recent developments

To prevent work-related mental health problems OP and GP interventions alone are not sufficient. Employer and employee organizations increasingly realize the positive health and economic impact of primary prevention, e.g. reducing workload, stimulating social support at work, early detection and adequate handling of work conflicts. A Dutch all-party committee developed an overall guideline for managers, employees, physicians and other care providers. Evaluation showed that GPs play a key role, but often they are too passive, keeping patients at home too long²⁷.

Given this consideration and a lack of authorized cooperation guidelines the Dutch GP and OP associations recently developed a primary care collaboration agreement on psychological problems²⁸. The results of this study can support its implementation.

International relevancy

Given the global stress epidemic¹ and the lack of OHS coverage, GP management of work-related diseases is important, also from occupational health perspective. However, many GPs seem to have a Blind Spot for work-relatedness, also outside The Netherlands²⁹. Accordingly, this GP-guideline can be applied in various countries.

GP-OP coordination needs international improvement (BMJ editorial³⁰), given the WHO 1994 goal OHS for all, and regarding the tendency, that in many countries OPs increasingly have to deal with sick leave³¹. Still few GPs contact OPs³², although OP interventions at mental problems,

following practice guidelines, have proven to be effective in preventing long-term sick leave and relapse³. GPs can play an important early-warning role³³. Moreover, 30% of British OPs re-evaluated their case management after contact with attending physicians³⁴, like GPs in our study re-evaluated their treatment after contact with an OP.

Conclusions

1. Many employees with work-related psychological complaints visit a GP, although GPs often do not pay attention to work-relatedness or cooperation with OPs.
2. Guidelines in this field were missing, consequently we developed and tested one.
3. Although a pilot study showed the new guideline needs further improvement, GPs were quite satisfied, indicating positive effects on sickness absence. Patient satisfaction was high, especially on GP-OP contact.
4. The pilot study shows that the OP image and GP awareness of work-relatedness needs further improvement.
5. Regarding these pilot results we recommend to test an improved, more efficient guideline, including more OP commitment, in a Randomized Controlled Trial design, if possible in various countries.

Acknowledgement

We thank the participating GPs and patients for their cooperation, and NWO and AGIS Health Insurance for their financial support.

References

- 1) Rantanen J (2004) New challenges for OHS. In: Key lecture, 12th ICOH Congress, Modena 14 Oct. 2004 Book of Abstracts, ICOH, Modena.
- 2) Einerhand M, Stelt H vd (2005) Growing disability rates; the gender issue. The Dutch case. *Internat Soc Secur Review* **58**, 65–84.
- 3) Klink JJL van der, Blonk RWB, Schene AH, Dijk FJH van (2003) Reducing long-term sickness absence by an activating intervention in adjustment disorders: a cluster randomised controlled design. *Occup Environ Med* **60**, 429–37.
- 4) Shiels C, Gabbay MB, Ford FM (2004) Patient factors associated with duration of certified sickness absence. *Br J Gen Pract* **54**, 86–91.
- 5) Cartwright S, Cooper CL (1997) *Managing Workplace Stress*, Sage Publications, London.
- 6) ILO (1993) *Job stress: The 20th century disease*. World Labour Report no 6, United Nations Labour Office, Geneva.

- 7) Ministry of Health, Labour and Welfare (2005) Annual report on Health, Labour and Welfare 2003–2004. Health Risk Surrounding Modern Life-Attaining Safety and Peace of Mind with Information and Collaboration, International Corporation of Welfare Services (JICWELS), Tokyo.
- 8) Sigel P, Leiper R (2004) GP view of their management and referral of psychological problems: a qualitative study. *Psychology and Psychotherapy: Theory, Research and Practice* **77**, 279–95.
- 9) Andrea H, Metsemakers JFM, Kant Y, Beurskens AJHM, Swaen GMH, Schayck CP v (2004) Seeking help in relation to work—visiting the occupational physician or the general practitioner. *Occ Med* **54**, 419–21.
- 10) Buijs P, van Amstel R, van Dijk FJ (1999) Dutch occupational physicians and general practitioners wish to improve co-operation. *Occup Environ Med* **56**, 709–13.
- 11) Anema JR, Jettinghoff K, Houtman I, Schoemaker C, Buijs PC, Berg R vd (2006) Medical care of employees long-term sick listed due to mental health problems: a cohort study to describe and compare the care of the OP and GP. *J Occup Rehabil* **16**, 41–52.
- 12) Buijs PC (2001) A lack of coordination between OPs and treating physicians was known for years, but not recognized. *TBV (Dutch Sci J Occup Med)* **9**, 133–8.
- 13) Buijs P, Tudor Hart J (1997) Why Dutch GPs do not certify. *Br J Gen Pract* **12**, 860–1.
- 14) Nauta AP, Weel ANH, Overzier P, Grumbkow J von (2006) The effects of a joint vocational training program for general practitioners and occupational health trainees. *Med Educ* **40**, 980–6.
- 15) Friedli K, King MB, Lloyd M, Horner J (1997) Randomised controlled assessment of non-directive psychotherapy versus routine general-practitioner care. *Lancet* **350**, 1662–5.
- 16) Nederlandse Organisatie voor Natuur-Wetenschappelijk Onderzoek (NWO). Research program Fatigue at work. <http://www.psychischenwerk.nl>. Accessed January 1, 2006.
- 17) For GPs a brief description of the guideline has already been published: Buijs PC, Anema JR, Evers M, Dijk FJHv, Klink, JLLvd (2006) How GPs can manage work-related psychological complaints: design and pilot of a guideline. A contribution to solve a big problem. *Eur J of Gen Pract* **12**, 138–41.
- 18) Klink JLL van der, Dijk FJ van (2003) Dutch practice guidelines for managing adjustment disorders in occupational and primary health care. *Scand J Work Environ Health* **29**, 478–87.
- 19) Anema JR, Buijs PC, van Putten DJ (2001) Cooperation between general practitioner and occupational physician. A practical guideline. *Med Contact* **20**, 790–3.
- 20) Wlodarczyk K, Parker G (2004) Occupational health and general practitioners. *BMJ careers* **21**, 73–4.
- 21) Cabana MD, Rand CS, Powe NR (1999) Why don't physicians follow clinical practise guidelines? A framework for improvement. *JAMA* **282**, 1458–65.
- 22) Hulshof CTJ, Broersen JPJ, De Haan S (2002) Samenwerkingsrichtlijn 1^e lijns handelen bij psychische klachten en arbeid. Evaluatie fase 2: praktijktest (Primary care cooperation guideline on mental complaints and work), PARAG/SKB, Utrecht/Amsterdam (in Dutch).
- 23) Venama A, Anema JR, Amstel RJ van, Nauta AP, Verbeek JH, Putten DJ van, Buijs PC (2005) Samenwerking tussen huis- en bedrijfsartsen (Cooperation between GPs and OPs). *TSG (J Soc Med)* **13**, 286–90 (In Dutch).
- 24) Anema JR, Amstel RJ (2004) Sickness absence management at low back and mental complaints and patient assessment. *TBV (Dutch Sci J Occup Med)* **12**, 195–203.
- 25) Nieuwenhuijsen K (2004) Employees with common mental disorders: from diagnosis to return to work. Thesis 139. Univ of Amsterdam, Amsterdam.
- 26) Huibers MJH (2003) Fatigue among employees. Treatment in primary care. Thesis 193, Univ of Maastricht, The Netherlands.
- 27) Commissie Werkend Perspectief (2004) Samen beter worden (Together getting better), Hoofddorp, The Netherlands.
- 28) Romeijnders ACM, Vriezen JA, van der Klink JLL, Hulshof CTJ, Terluin B, Flikweert S, Baart PC (2005) A national primary care agreement on overstrain (Landelijke eerstelijns samenwerkingsafspraken overspanning), Huisarts en Wetenschap 2005.
- 29) Buijs PC, Weel AN (2005) A blind spot for work in general health care: therapies from abroad for a Dutch problem? Report for the Dutch Department of Labour, 23-9-2005, Hoofddorp, The Netherlands (See also: Hoffman H, Guidotti TL (1994) Basic clinical skills in occupational medicine. *Primary Care* **21**, 225–36).
- 30) Beach J, Watt D (2003) General practitioners and occupational health professionals. Consensus statement to improve interaction is timely and welcome. *BMJ Editorial* **372**, 302–3.
- 31) European Foundation (1997) Preventing absenteeism at the workplace. Research summary, 93, Dublin.
- 32) Nauta AP (2004) A matter of trust: about GP-OP-cooperation. Thesis, 141–2, Open University, Heerlen, The Netherlands.
- 33) Dijk PCM van, Hogervorst VWG, Buijs PC, Dijk FJH van (2006) The potential role of Dutch GPs in imminent long-lasting sickness absence. *Eur J Gen Pract* **12**, 74–6.
- 34) De Bono AM (1997) Communication between an occupational physician and other medical practitioners—an audit. *Occup Med* **47**, 349–56.