NHG Position Paper

Core values of General Practice / Family Medicine

Dutch College of General Practitioners

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Position Paper
Core Values of General Practice/Family Medicine

generalist, patient-oriented and continuous care

Foreword

General practice medicine is generalist, patient-oriented, continuous care. These core values are inextricably linked to each other. The quality of general practice/family medicine can only be described by viewing these core values in their mutual connection.
The GPs actions at the practice are based on these core values.

The GP deals with the public's complaints, problems and questions in regard to health and illness. This generalist principle is closely connected to the individualized character of and to continuity in health care. The general practitioner applies his medical knowledge and skills and combines these with his knowledge of the patient's course of life and medical history in his living and work environment and social context. Furthermore, the GP is the one constant factor in medical care for the patient over a longer period of time, during both health and illness.

The core values of general practice/family medicine are not new and have long been the foundation of general practice care. However, the context in which these core values are implemented by GPs in practice are constantly subject to change. Both the context of request for care and the context of the care offer have their own dynamics. While in the past the GP was a family doctor with a homogeneous patient population, today he[1] has to deal with a large diversity within the patient population, with ageing and with many differences between and changes in the family unit and cohabitation relationships. Ethnic diversity has increased in recent years. Some 20% of the population in the Netherlands is of non-Dutch origin. And patients' attitudes are changing as well. They are amassing knowledge about their medical issues and often want to be actively involved in finding the right treatment for their illness. A portion of society – primarily highly educated people – has consciously adopted healthier living habits. Thanks to increasing technological developments, expectations are growing in regard to treatment options and prevention. As a result of increased market thinking within society and the 24-hour economy, health care is having to deal with commercialization and shifting expectations in regard to service and availability.
Due to the shift of tasks from secondary to primary health care institutions and shortened hospital stays, the GP is also facing an expansion of his range of tasks.

Even the context of the professional group itself is different than it was several decades ago. More and more GPs are working part-time in larger group practices. More task delegation and task differentiation is taking place within GP practices. What all of these developments have in common is that when a patient visits the practice, he is not always seen by his own general practitioner.

[1] For stylistic reasons, we have opted to avoid the use of the designations 'he/she' and 'his/her' in this document. Whenever applicable, the designations 'he' and 'him' refer to both male and female persons.

General practice medicine is highly adaptive and is continually adapting itself to these changes. The challenge for this field is to fully implement the core values in a generalist, patient-oriented and continuous manner in this dynamic context. This Position Paper aims to contribute to the above as the first step in developing a Future Vision 2022.

Contents

1. INTRODUCTION

The history of general practice/family medicine's core values go back to the Woudschoten Conference in 1959. There, general practice/family medicine was described as 'the provision of continuous, integral, personal care for the individual and the family.'[2] These basic principles have since become entrenched in the GPs essence.

Many decades later, a future vision for the medium term was issued for the first time. The core values of generalist, patient-oriented and continuous care were the foundation of the Future Vision of General Practice Care 2012 (Dutch: Toekomstvisie Huisartsenzorg 2012) and of its concretization in general practice care and the general practice facility.[3, 4] These core values can also be encountered in the European definition of general practice/family medicine.[5]

The Future Vision of General Practice Care 2012 has been the guideline in recent years for innovation at the practice, for the representation of interests and for the policy and product development of LHV and NHG. The Future Vision also acts as a compass for general practitioner education and the quality policy.

In order to shape the Future Vision, the NHG and LHV published Position Papers and Advice about patient care and about the organisation of this care, specifying and substantiating the vision of various parts of general practice care and providing practical recommendations. Topics discussed include general practice care for the elderly and for children, caring for patients with a frequently occurring chronic illness and palliative care.

Position Paper on Core Values of General Practice Medicine and the Future Vision of General Practice Care 2022

This Position Paper represents a link between the Future Vision of General Practice Care 2012 and the Future Vision 2022, which will be determined by the NHG and LHV at the end of 2011. On the one hand, the Position Paper on the Core Values of General Practice Medicine describes the foundation for the innovations in patient care and the practice organisation (based on the Position Papers and Advice) which shaped the Future Vision 2012. On the other hand, the Position Paper on the Core Values of General Practice Medicine also represents the starting point for the Future Vision 2012.

This Position Paper on the Core Values of General Practice Medicine describes the essential characteristics of general practice medicine. The Future Vision of General Practice Care 2022 explains how these core values can be implemented in general practice care in the coming years.

The modernisation of general practice care cannot be viewed separately from developments in society and health care and the (financial) framework context in which general practice care functions. In the Future Vision of General Practice Care 2022, this context from general practice/family medicine (i.e. the core values) is discussed with a focus on, among other things, the development of health care offer, cooperation with other health care providers and the consequences for practice organisations, education and research.

[2] Huygen FJA. De huisarts en de wetenschap. (The general practitioner and science.) Med Contact 1956;11:730-9.
[3] Toekomstvisie Huisartsenzorg 2012 (Future Vision of General Practice Care 2012). Utrecht: NHG/LHV, 2002.
[4] General practice care and the general practice facility. Concretization of the Future Vision of General Practice Care 2012. Utrecht: NHG/LHV, 2004.
[5] See appendix I for the European definition of general practice/family medicine.

Bookmark
The core values of general practice/family medicine of generalist, patient-oriented and continuous care are illustrated in three chapters. Chapter 6 provides a point-by-point overview of the manner in which the core values are manifested in practice. Appendix I contains a complete overview of the above-mentioned Position Papers and advice based on the Future Vision of General Practice Care 2012, and Appendix II features the European definition of general practice/family medicine. The Position Paper is prepared by a work group. Appendix III explains the compilation and materialization process of the Position Paper.

2. CORE VALUES OF GENERAL PRACTICE MEDICINE

General practice medicine is generalist, patient-oriented, continuous care.

Generalist
General practice medical care is generalist care. Generalist means that the GP is open to all possible complaints, problems and questions about illnesses and health from everyone, young and old alike. The GP possesses the necessary knowledge and skills to adequately assess these complaints, problems and questions and to take action based on his assessments or to give the patient advice or refer him to another physician, all while taking into consideration the natural disease progression.

Patient-oriented
General practice medical care is patient-oriented care. This means that the GP takes into account the patient's individual characteristics and the patient's context. We use the word 'context' here to mean the course of the patient's life and his living and work environment. The GP integrates context knowledge with physical, mental and social aspects that can influence the patient's health and illness.

Continuous
General practice medical care is continuous care. This means that the GP is the one constant factor in health care for the patient. He ensures continuity of care during periods of illness and during the patient's general course of life. The GP works together with other health care providers through his directional role for cohesion in health care.

The core values of general practice/family medicine are described in more detail in the next chapters but are inextricably linked in practice.

3. GENERAL PRACTICE MEDICINE IS GENERALIST CARE

General practice medical care is generalist care. Generalist means that the GP is open to all possible complaints, problems and questions about illnesses and health from everyone, young and old alike. The GP possesses the necessary knowledge and skills to adequately assess these complaints, problems and questions and to take action based on his assessments or to give the patient advice or refer him to another physician, all while taking into consideration the natural disease progression.

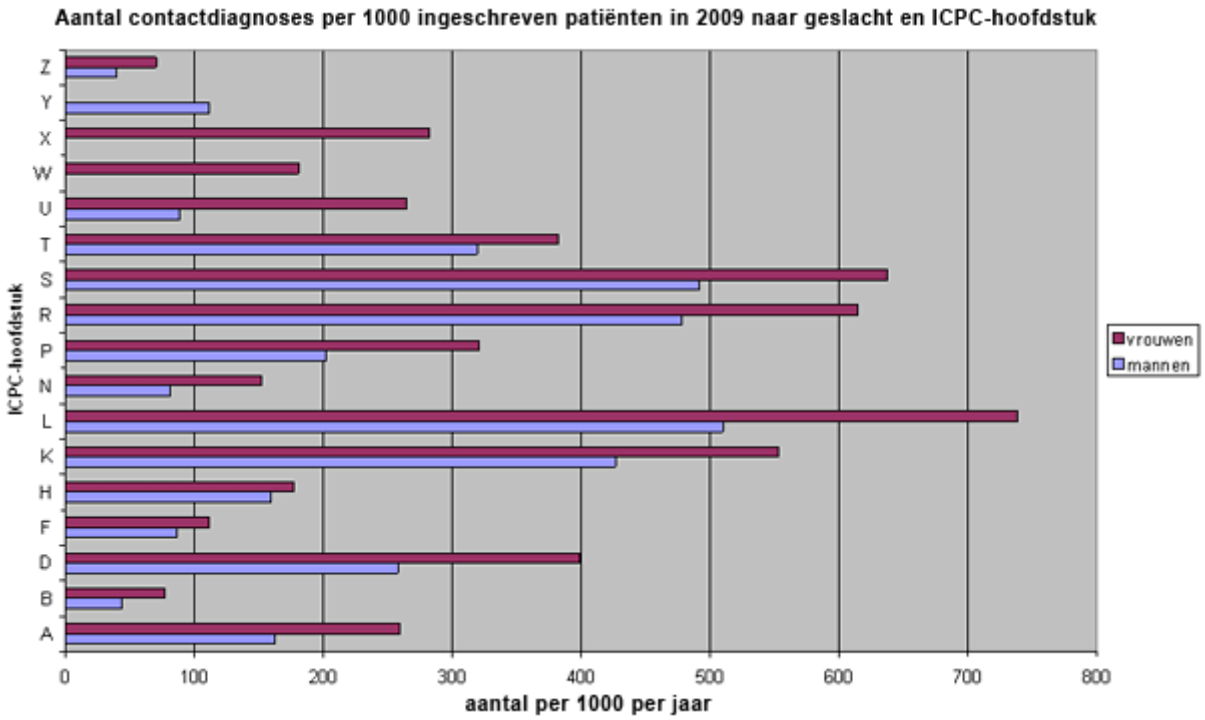
Anyone can visit the general practitioner with his health problems, complaints and questions. General practice medicine is complex because the GP deals with all sorts of people and all possible health problems that can occur simultaneously.[6] The GP maintains a cross-discipline approach as his working method, whereby the patient's personal situation and background is also considered (Chapter 4, explanation of the patient-oriented core value). What is characteristic for the GP is that he deals with all sorts of complaints, in all phases of the course of the illness. The patient's request for help is often the starting point in regard to contact with the patient.

Clarifying this request for help is one of the GPs core qualities.
The GP often sees patients with undifferentiated complaints. These complaints can hide a variety of ailments. The GP distinguishes himself from other medical specialists in this regard, who deal with selected and/or referred patients and who focus on a specific part of the human body/function. The generalist working method is holistic in the sense that the GP works on 'parts with attention to the whole'.[7]

3.1 For all complaints, problems and questions

As the first point of contact, the GP deals with all sorts of questions, frequently occurring and rare complaints and health problems that can be acute or chronic in nature. The following figure illustrates the wide range of complaints and disorders with which the GP deals.

[6] Katerndahl DMD, Wood RPH, Jaén CR. Family medicine outpatient encounters are more complex than those of cardiology and psychiatry. J Am Board Fam Med 2011;24:6-15.
[7] Stange KC. The paradox of the parts and the whole in understanding and improving general practice. Int J Qual Health Care 2002;14(4):267-8.



Text for Graphic:

Number of contact diagnoses per 1,000 registered patients in 2009 according to gender and ICPC chapter

ICPC chapter **number per 1,000 per year** **Women** **Men**

The y-axis of this table lists the 17 categories ('organ systems') used to record complaints and disorders in general practice according to the ICPC.[8]
The x-axis indicates the number of diagnoses in these different categories. This table shows that patients consult the GP for complaints and disorders relating to all organ systems and stresses the generalist character of care in general practice/family medicine.[9]

Broad medical knowledge
Care in general practice/family medicine includes diagnostics and the treatment of frequently occurring complaints and disorders.[10] A prevalence of > 2/1,000 registered patients is the indication of 'frequently occurring'. The GP has the knowledge and skills to make a diagnosis for the 400 most frequently occurring disorders and the 80 most frequently occurring complaints and to help patients with frequently occurring complaints and to treat them, if necessary, without referring them to other health care providers. He bases his actions on the principles of evidence-based medicine to the greatest extent possible. There were evidence is lacking, the GPs actions are based on professional experience and insights. He knows the complaints and symptoms of rare disorders so that he can also detect these in a timely manner.

[8] The ICPC classification system categorizes complaints and disorders into the following sections: A=general and non-specific, B=blood and blood-forming organs, D=digestive organs, F=eye, H=ear, K=cardiovascular , L=locomotor apparatus, N=nervous system, P=psychological problems, R=respiratory system, S=skin and subcutaneous tissue, T=endocrine glands/metabolism/nutrition, U=urinary tracts, W=pregnancy/birth/birth control, X=female sex organs and breasts, Y=male sex organs and breasts, Z= social problems.
[9] Verheij RA, Van Dijk CE, Stirbu-Wagner I, Visscher S, Abrahamse H, Davids R, Braspenning J, Van Althuis T, Korevaar JC. Landelijk Informatienetwerk Huisartsenzorg (National Information Network for General Practice Care). Facts and figures on general practice care in the Netherlands. Utrecht/Nijmegen: NIVEL/IQ, 2009, [http://www.nivel.nl/oc2/page.asp?pageid=14023], visited on 20 February 2011.
[10] Basic offer of care in general practice/family medicine. Utrecht: LHV, 2009.

He is familiar with therapy for frequently occurring and complex health problems, certainly to the extent that these are described in the NHG Standards. He possesses an extensive arsenal of treatments, varying from the wait-and-see policy, evidence-based pharmacotherapy, conversation techniques to (small) surgical procedures.

Diagnostics
The patient consults the GP often at an early stage, when the first symptoms occur and the patient becomes worried. It is sometimes difficult to make a diagnosis at such an early stage. The GP has knowledge of and experience with making a differential diagnosis based on epidemiological knowledge in combination with an assessment of the individual patient's situation. The starting points for a diagnosis can largely be found in the patient's personal story.[11] This illustrates the connection between the generalist and patient-oriented core values (see also Chapter 4, explanation of the patient-oriented core value). In addition to making a diagnosis, the GP is usually able to give the patient an adequate prognosis about his health problem. This is also of great value to the patient.

The time factor in diagnosis
Sometimes, when a certain diagnosis can not (or not yet) be made, the GP will make a symptom diagnosis and exclude acute, serious disorders. The advice to the patient may then be to wait and see the course of the illness and, if necessary (based on the GPs instructions, e.g. if the symptom persists or worsens), to have the GP re-evaluate the complaints and symptoms at a later time ('watchful waiting'). Watchful waiting is an essential part of the GPs work. A long-term, personal GP-patient relationship based on mutual trust makes it easier to employ a policy of 'watchful waiting' when the occasion warrants and reassure the patient.

Risk assessment
Risk assessment is among the GPs core competencies. This also applies to weighing the advantages and disadvantages of prevention and of medical interventions.[12] Some choices, such as not making a diagnosis, which is associated with risks, are sometimes difficult to explain. Patients often have high expectations of diagnostic and therapeutic possibilities. In these cases, the GP tries to prevent iatrogenic damage as much as possible by acting and providing advice in a scientifically substantiated manner as this translates to the individual patient's situation.

Prevention
Disease prevention is a core task of general practice/family medicine to the extent that this is sufficiently scientifically substantiated. Due to his long-term relationship with the patient and his knowledge of the patient population, the GP is pre-eminently qualified to contribute to prevention at the individual level as well as the practice population level.[13] Three-quarters of all registered patients comes in to the general practice at least once per year.
The role of the GP in prevention is described in various NHG Standards. The NHG Standard Prevention Consult offers the methodology for timely detection and treatment of people with an elevated health risk in the primary health care system. The first module, Cardiometabolic Disease, is aimed at detecting people with a risk of cardiovascular disease, diabetes and kidney damage. This NHG clinical guideline offers possibilities for implementing scientifically substantiated preventive activities at the general practice, including with the participation of other health care providers.[14]

[11] Peterson MC, Holbrook JH, Hales DV et al. Contributions of the history, of physical examination, and of laboratory investigation in making medical diagnosis. Western Journal of Medicine 199;156:163-5.
[12] Characteristics of the discipline of general practice/family medicine, general practice care and the general practice facility. Concretization of the Future Vision of General Practice Care 2012. Utrecht: NHG/LHV, 2004.
[13] Drenthen AJM, Assendelft JJ, Van der Velden J. Preventie in de huisartsenpraktijk: kom in beweging! (Prevention at the general practice: Get a move on!) Huisarts Wet 2008;1:38-41.
[14] For more information, go to: www.nhg.org\PreventieConsult.

For screening activities, the criteria of Wilson and Jungner are the starting point.[15] Involvement of the GP in systematic prevention results in a high degree of participation, such as in screening for cervical cancer and the flu vaccine.[16]

First, do no harm
The *primum non nocere* (the 'first, do no harm' principle) is an important basis in general practice/family medicine. This is employed against the backdrop of the patient's entire functioning. The applicable standard is that only those interventions are done whose benefit has been demonstrated.[17] In his work, the GP uses the knowledge as specified by the NHG Standards, pharmacotherapeutic guidelines, other (multidisciplinary) guidelines and the expertise amassed by the professional group in the area of frequently occurring complaints and disorders.[18] The medication policy is based on existing evidence. The basic rule is that preference is given to the effective and cost-efficient prescription of proven medications that have the fewest possible side-effects.[19]

Additional knowledge and experience
Job differentiation means that GPs share their knowledge and experience with their colleague GPs, among other things by providing (additional) training, giving consultation and advice and developing the practice organisation or regional care projects. This concerns GPs who, in addition to their generalist knowledge and skills, have more comprehensive expertise in a (clinical) field because they have had specialised training and have amassed a lot of experience with a specific patient group or disorder. These GPs with additional expertise and experience provide an incentive for the development of general practice/family medicine and help all GPs gain access to in-depth knowledge across the entire range of general practice/family medicine through colleague GPs.

3.2 For everyone

The GP provides care for everyone: young and old, from various cultural, ethnic and social backgrounds. The diversity of patients has consequences for the GPs actions due to differences in epidemiology and genetic factors.

For chronic and commonplace illnesses, the social-economic status (SES) is an important predictor of disease progression, prognosis and the effectiveness of interventions. There are major social-economic status health differences in the Netherlands.[20] Among the population group with the least education, the incidence of chronic illnesses is 50% higher than in the population group with the most education. On average, Dutch people with the least amount of education die six to seven years earlier than the highly educated. The difference in life expectancy without physical limitations between the highly educated and those with the least education is 14 years.[21] (For the societal dimension of the GPs work,

[15] Screening tussen hoop en hype. Den Haag: Gezondheidsraad, 2008. (Screening between hope and hype. The Hague: Health Council of the Netherlands). See also the NHG Position Paper on medical check-ups for people without medical complaints, 2008.
[16] De Nooijer DP, De Waart FG, Van Leeuwen AWFM, Spijker WWJ. Opkomst bevolkingsonderzoek naar baarmoederhalskanker hoger na uitnodiging door huisarts, in het bijzonder voor groepen met doorgaans lage participatiegraad. (Participation in cervical cancer screening is higher when requested by general practitioners, especially for groups with a generally low participation level.) Ned. Tijdschr Geneeskd 2005;149:2339-43. Tacken M. Opkomst baarmoederhalskankerscreening: huisartsen organiseren het goed. (Participation in cervical cancer screening: general practitioners do a good job organising). Huisarts Wet 2002;45:109.
[17] General practice care and the general practice facility. Concretization of the Future Vision of General Practice Care 2012. NHG/LHV,2004.
[18] Eekhof JAH, Knuistingh Neven A, Verheij ThJM, draft. Kleine kwalen in de huisartspraktijk (Small ailments in the general practice). Maarssen: Elsevier, 2007 (fifth fully revised printing).
[19] Position Paper on Pharmacotherapy Policy in General Practice Care. Utrecht: NHG, 2006.
[20] Mackenbach, JP. Ziekte in Nederland. (Illness in the Netherlands). Amsterdam, Elsevier Gezondheidszorg, 2010.
[21] Lucht van der F, Polder J Van gezond naar beter (From healthy to better). Kernrapport Volksgezondheid Toekomstverkenning (Key Report on Public Health Forecast). 2010, Bilthoven, RIVM, 2010.

see section 4.3. Population orientation.)

Our country has around 3.3 million people who were either themselves born abroad or who have at least one parent born abroad (the immigrants); of these people, some 1.8 million are not of western origin.[22] According to demographic estimates, one-third of the population in the Netherlands will be of non-western origin in 2050.[23] Immigrants feel less healthy than other Dutch people and have more chronic illnesses.[24] Differences in disease perception and expectations in regard to health care complicate medical care.[25] Immigrant patients visit the hospital more often compared to non-immigrant Dutch of the same age, education level, SES or subjective health.[26] In contrast, they make less use of physical therapy and home care. The differences in the use of care vary per ethnic group.[27] The NHG Standards are increasingly focusing on ethnic-cultural diversity.

Certain groups, such as immigrants, the elderly and children, require special attention in regard to communication. With immigrant patients, the GP must bear in mind language barriers and cultural differences which influence communication. Many older immigrants or newcomers do not know sufficient Dutch in order to understand a consult properly: 90% of immigrants over age 55 need language assistance for a GP consult.[28] Given that the GP is responsible for establishing the framework for good communication according to the WGBO (Dutch Medical Treatment Act), he calls upon a professional interpreter when necessary and if possible.[29]

With the elderly, the GP must keep in mind possible decreased cognitive and sensory function.[30] Children are directly involved in communication by the GP during a consult, keeping in mind their capabilities and development.[31]

3.3 Education, continuing education and quality policy

The basis for the GPs broad medical expertise is formed during his education, including developing skills in many specialist subject matters.
An important element in the generalist's development is amassing experience with the manifestation of a large variety of complaints and disorders in his patient population. The frequent contact with patients suffering from a variety of complaints and disorders leads to quick recognition of patterns and thus also of any deviating and possibly serious disease progression. In order to amass and maintain knowledge and experience in the full scope of the field, it is very important for the GP to have contact with various patients. For this reason – as well as from the Position Paper of guaranteeing the patient-oriented approach (see Chapter 4, Individual-oriented) – the GP needs to be approachable and accessible for all possible patient health questions. The GP takes this into account and ensures that he

[22] CBS statline 22-12-2010.
[23] CBS statline, immigrant prognosis 2007-2050.
[24] Kunst A, Mackenbach J, Lamkaddem M, Rademakers J, Devillé W. Overzicht en evaluatie van resultaten van wetenschappelijk onderzoek naar etnische verschillen in gezondheid, gezondheidsrisico's en zorggebruik in Nederland (Overview and evaluation of results of scientific research of ethnic differences in health, health risks and care use in the Netherlands). Study on behalf of ZonMw. 2008.
[25] Campbell JL, Ramsay J, Green J. Age, gender, socioeconomic, and ethnic differences in patients' assessments of primary health care, Qual Health Care 2001;10:90-95. Uiters E, Primary health care among ethnic minorities in the Netherlands, A comperative study [Dissertation] Utrecht: Nivel, 2007.
[26] Devilee 2008 Walter L.J.M. Devillé , Ellen Uiters, Gert P. Westert, Peter P. Groenewegen Perceived health and consultation of GPs among ethnic minorities compared to the general population in the Netherlands. In: Dutch general practice on stage: morbidity, performance and quality in an international scene. Westert GP, Jabaaij L, Schellevis FG(eds). Radcliffe, Oxford, 2006.
[27] Uiters E. Allochtonen en de Nederlandse gezondheidszorg. Primary health care use among ethnic minorities in the Netherlands [Dissertation]. Utrecht: NIVEL, 2007.
[28] Schellingerhout R. Gezondheid en welzijn van allochtone ouderen (Health and wellness of the immigrant elderly). The Hague: Sociaal en Cultureel Planbureau (Netherlands Institute for Social and Cultural Research), 2004.
[29] Health Inspectorate: survey of interpreters in health care, 2003.
[30] NHG Position Paper on General Practice/Family Medicine for the Elderly. Utrecht: NHG, 2007.
[31] NHG Position Paper on General Practice Care and Youths. Utrecht: NHG, 2008.

maintains and develops his broad subject-matter expertise through comprehensive practical experience and high-quality, practice-oriented further education/additional training.[32]

In addition to medical expertise, the professional attitude and skills in the area of communication, cooperation and consultation are essential for implementing the core values of general practice/family medicine. This also includes the skill of involving the patient in making decisions about (possible) treatments (shared decision making) whenever possible and the skill to support the patient in independently dealing with (the consequences of) illness. Here too the foundation is laid during the GPs education. Peer review and supervision are good methods for practicing GPs to discuss issues they encounter in their everyday work and to receive feedback from colleagues. This is not only supportive but also contributes to further development of skills in the area of communication, cooperation and professional attitude.[33]

In view of the quality policy, the recommendation is for the diversity and the specific character of general practice medical care (generalist, patient-oriented and continuous) to manifest themselves in the quality criteria for the NHG Practice Accreditation.

3.4 The 'generalist' core value in parts of general practice care

The GP makes an essential contribution to acute care.[34] He can assess whether or not a physical or psychological disorder is of an urgent nature and can adjust his actions accordingly. Practice has proven that this takes place during evening, night and weekend duty in a good, target-oriented and cost-effective manner at the after-hours doctor's offices.[35]

Physical and social problems regularly hide behind somatic complaints and issues, while chronic somatic illnesses increase the chance of psychological problems. The GP watches for psychological problems and counsels, treats or refers patients depending on the severity of the problem.[36]

Caring for patients with frequently occurring chronic illnesses such as diabetes mellitus, asthma and COPD, has developed into high-quality, systematic primary care, whereby these patients rarely need to visit secondary care institutions.[37] Practice assistants and nurse practitioners play an important role in this respect.[38,39]

Two-thirds of all people over age 65 have two or more chronic illnesses.[40] This group will grow quite a bit due to the double ageing in the coming years: from 1 million currently to 1.5 million in 2020. Care for these patients is difficult to control due to the complexity and the changing combinations of illnesses and limitations. Already existing multimorbidity can make diagnosing a new (chronic) disorder difficult.[41] The (drug) treatment of one illness can interfere with that of another.[42]

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[32] In this light, an annual exam focusing on generalist knowledge and skills would be helpful so that the GP can focus his further education/additional training on any existing gaps.

[33] NHG and LHV are working together with IQ Health on a system for educational evaluation of the individual functioning of the GP. This method uses self-evaluation and a 360-degree feedback round amongst colleagues and patients, among other things.

[34] Position Paper on the Contribution of General Practice Medicine to the Acute Chain of Care. NHG, 2005.

[35] Giesbers S, Smits M, Giesen P. Zelfverwijzers SEH jagen zorgkosten op. Medisch Contact 2011;10:587-9.

[36] NHG Position Paper on GGZ in General Practice Care. Utrecht: NHG, 2007.

[37] Position Paper on Care for Patients with a Frequently Occurring Chronic Illness in the Primary Care System. Utrecht: NHG, 2005. With versions for type 2 diabetes mellitus (2005), asthma/COPD (2005) and cardiovascular risk management (2007).

[38] Laurant MGH, Hermens RPMG, Braspenning JCC, Sibbald B. Impact of nurse practitioners on workload of general practitioners: randomized controlled trial. British Medical Journal 328 (7445); 927-30.

[39] Concept Position Paper on The (Supporting) Team at the General Practice Facility. Utrecht: NHG 2011.

[40] Ouderdom komt met gebreken (Age comes with deficiencies). The Hague: Health Council of the Netherlands, 2008.

[41] Aarts SM, Van den Akker, Tan F, Verhey F, Metsemakers J, Van Boxtel M. De invloed van multimorbiditeit op het cognitief functioneren (The influence of multimorbidity on cognitive functioning). Huisarts Wet 2011;54:128-32.

In view of pharmacotherapy policy, cooperation agreements with pharmacists are important. The added value of the GPs generalist approach is pre-eminently showcased when treating older patients with multimorbidity and polypharmacy. In these cases, the generalist approach means that the GP – in consultation with the patient – sets priorities in the treatment plan, taking into account interactions and side-effects of medicines, therapy loyalty and the consequences that (the treatment of) the various disorders have for the patient.[43] If treatment no longer appears to be possible, then the focus will shift to maintenance or restoration of functionality, the ability to live independently and perceived quality of life.[44]

3.5 The 'generalist' core value in practice

1. The GP has the knowledge to make a diagnosis for the 400 most frequently occurring disorders and the 80 most frequently occurring complaints.
2. The GP also recognises the complaints and symptoms of less frequently occurring disorders.
3. Thanks to his knowledge of his patient's context, he is able to weigh the predictive value of complaints and symptoms and to recognise symptoms with a possibly serious origin and to discern the patient's fear thereof.
4. The GP works in a cross-disciplinary manner and bases his actions on the principles of evidence-based medicine to the greatest extent possible. He possesses an extensive arsenal of treatments, varying from the wait-and-see policy, evidence-based pharmacotherapy, conversation techniques to (small) surgical procedures.
5. The GP is familiar with therapy for frequently occurring and complex health problems, certainly to the extent that these are described in the NHG Standards.
6. The GP is able to provide information about most disorders to the patient in regard to the expected course of the illness as well as to advise the patient and, if necessary, propose a wait-and-see approach for 'self-limiting' disorders.
7. The GP applies prevention at the individual level by influencing risk factors based on the available guidelines. He is also involved in vaccinations and early diagnosis within the scope of medical screening.
8. The GP is capable of dealing with patients with multimorbidity and polypharmacy. He involves the patient in setting priorities in regard to diagnosis and treatment, taking into account the consequences in terms of the expected benefits and side effects.
9. The GP possesses the attitude and communication skills to respectfully and adequately communicate with the patient, regardless of the patient's age, gender, social-cultural background and cognitive and sensory limitations.
10. The GP maintains his generalist knowledge and skills by means of multifaceted further education/additional training.

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[42] Schellevis F. Multimorbiditeit in de huisartsenpraktijk: je gaat het pas zien als je het door hebt (Multimorbidity in the general practice: you don't see it until you get wise to it). Huisarts Wet 2007; 9:452-54.

[43] NHG is working on a multidisciplinary polypharmacy guideline for the elderly: towards a better medication policy, in cooperation with the Nederlandse Vereniging voor Klinische Geriatrie (Netherlands Clinical Geriatrics Association), de Orde, Verenso (Professional Association of Nursing Home Doctors and Social Geriatricians), Nederlands Instituut voor Verantwoord Medicijngebruik (Dutch Institute for the Proper Use of Medicine) and the KNMP.

[44] NHG Position Paper on General Practice Medicine for the Elderly. Utrecht: NHG, 2007.

11. The GP actively develops his own skills in the area of professionalism, communication and cooperation by participating in peer review, supervision or coaching.

4. GENERAL PRACTICE MEDICINE IS PATIENT-ORIENTED

General practice medical care is patient-oriented care. This means that the GP takes into account the patient's individual characteristics and the patient's context. We use the word 'context' here to mean the course of the patient's life and his living and work environment. The GP integrates context knowledge with physical, mental and social aspects that can influence the patient's health and illness.

When caring for a patient, the GP takes into account the patient's personal characteristics, age, gender and wishes and views. He takes into account the patient's living environment and his social and societal context. The GP considers somatic, psychological and social dimensions of the request for care in mutual correlation and he acts accordingly.[45] Knowledge of context can give the GP cause for being proactive. For example, for the purpose of preventing medical problems in the elderly [46] and when there are signals that could indicate psychosocial problems in families and the negative consequences of this for children.[47]
A large part of the effectiveness of general practice medical care can be attributed to this integral approach.[48]

4.1 Individual-oriented

The GP offers the patient customised care, taking into account the patient's gender, personal characteristics, preferences and course of life. This concerns not only the medical history but also the manner in which the patient deals with health and illness. The GP is able to help the patient in all phases of health and illness and adjust his working method to the patient's needs.[49]

The GP is responsible for ensuring that adequate help is offered to people who are not sufficiently capable of asking for this themselves such as the very old, people with psychiatric problems or a cognitive limitation, children and people with insufficient fluency in Dutch. These people often possess fewer health skills than others that are needed to be able to handle health and illness well.
In spite of the increased availability of information and options, even patients with good health skills are long not able to make choices by themselves under all circumstances.[50] Often emotions overshadow reality when patients don't feel well. With the patient-oriented approach, the GP is able to assist the patient as a guide and confidential advisor when making choices and, together with the patient, arrive at a care option that best suits the patient. In these situations, the GPs patient-oriented approach contributes to effective use of health care facilities and prevents iatrogenic damage and medicalization.[51]

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[45] General practice care and the general practice facility. Concretization of the Future Vision of General Practice Care 2012. Utrecht: LHV/NHG, 2004.
[46] The NHG Position Paper on General Practice Medicine for the Elderly explains in more detail the importance of a vigorous, proactive approach on the part of the GP.
[47] The Position Paper on General Practice Care and Youth discusses in more detail the importance of a proactive approach on the part of the GP in the care of children and families. For example, early detection of the negative consequences of (somatic or psychological) illnesses for children.
[48] Stange KC. The Generalist approach. Ann Fam Med 2009;7:198-203.
[49] Gerards RAE. Komt een patiënt bij zijn coach. Een nieuwe blik op patiëntenbeleid. (A patient comes to see his coach. A new view of patient policy.) The Hague: RVZ, 2010.
[50] Health skills are the individual competencies that are needed to be able to deal with health and illness. This presupposes that people are interested in and pay attention to their own health, that they can and want to collect, read or hear, understand and apply information about health. People possess these various characteristics to varying degrees and in varying forms. In particular immigrants, people with little education and the elderly encounter problems with finding and using information. Source: www.nigz.nl
[51] General Practice Medicine and the General Practice Facility. Concretization of the Future Vision of General Practice Care 2012.Utrecht: NHG/LHV, 2004.

4.2 Context-oriented

Family/relationship status

More than ever before, the GP has to deal with a great deal of variety when it comes to cohabitation relationships (families, one-person households, extended families, single-parent families), and changes occur more frequently within this variety. The role of the GP as a family doctor is less clear due to this.

There are standards, values and expectations within the family/cohabitation relationship, also with regard to dealing with health and illness. This is manifested in the frequency of consults with the GP and in the illness behaviour that typifies a family, such as dealing with stress. The chance of illness is often determined by familial aspects. The manner in which people handle illness is passed on within families.[52] The occurrence, course and prognosis of most disorders is largely determined by the interaction between genetic (familial) and environmental factors.

Work

Work, or a lack thereof, can lead to physical and/or psychological problems or disorders and is an important part of the patient's context. It is therefore important for the GP to know the type of work the patient does and to be alert to a possible interaction between work and health. Employees who are unable to work due to illness like to see the GP play a more prominent role when it comes to seeing them through their sickness absence.[53] Employees expect that their GP, just like their company doctor, will contribute to their recovery and return to work. During their absence from work, patients primarily value trust, independence and communication in their relationship with the GP .

Traditionally, the GP has been a confidential medical advisor who acts independently of the interests of third parties such as an employer or insurance company. Employees are quicker (and more apt) to knock on the GPs door than that of the company doctor for work-related health problems.[54] In this case, the GP also has the task of calling attention to (impending) work-related health problems and works together with the company doctor when necessary. In practice, GPs are unable to adequately carry out this task. In the interest of the patient's care, the GP must ask himself structurally whether the patient has a problem in the area of work and health, whether information is still missing after the problem has been clarified/assessed and whether the company doctor agrees with his findings and/or the company doctor needs to approve his advice.[55]

If the GP has a strong indication that structurally unhealthy conditions exists at an employer's premises, then he will contact the responsible company doctor about this.

In view of the patient-oriented approach and the use of relevant personal information for care, the GP also records relevant context information about his patient's family/cohabitation relationship, living situation and work in addition to their medical data. It is recommended that a 'family information list' be developed for the general practice information system (GPIS) in order to record relevant, objective information about the family/cohabitation relationship and the occurrence of hereditary and chronic disorders within the family.[56]

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[52] Cardol M, Groenewegen PP, De Bakker DH, Spreeuwenberg P, Van Dijk L, Van den Bosch WJHM. Gezinsgelijkenis in contactfrequentie met de huisartsenpraktijk: een retrospectief onderzoek. (Family resemblance in contract frequency with the general practice: a retrospective study.) Huisarts Wet 2005;1:3848. 490-4.

[53] Buijs P, Van den Heuvel F., Steenbeek R. Patiënten verwachten bij ziekteverzuim een prominente rol van de huisarts. (Patients expect the GP to play a prominent role during sickness absence.) Huisarts Wet 2009;3:147-51.

[54] Andrea H, Metsemakers JFM, Kant Y, Beurskens AJHM, Swaen GMH, Schayck CP. Seeking help in relation to work – visiting the occupational physician or the general practitioner. Occup Med 2004;54:419-21.

[55] Anema H, Buijs P, Van Amstel R, Van Putten D. Guidelines for general practitioners and company doctors regarding social-medical support during sickness absence. Utrecht: LHV/NVAB, 2002.

[56] This recommendation was made earlier in the NHG Position Paper on General Practice Care and Youths.

4.3 Population-oriented

A patient's living environment comprises an important part of the patient's context. Differences in health can be largely attributed to the social-economic circumstances in which people are born, grow up, live and work.[57]

The GP has a duty to call attention to factors in the neighbourhood that could be a detriment to health. This does not mean that the GP can always have a great deal of influence on this but rather that he points out risks and forwards these to the responsible entities. Examples of this are calling attention to the health risks of a lack of play space and sports facilities in the neighbourhood. Thanks to the frequent contact with patients in the neighbourhood, the GP also has an overview of situations that could be a detriment to health of vulnerable groups in the neighbourhood, such as the lonely elderly, unemployed youths and people with poverty issues.
The manner in which the general practice care is organised and localised – on a small scale and in the neighbourhood – makes it possible to tailor the care to the specific health situation of the registered population. Cooperation with the local council and other parties increases the GPs chances of working on prevention in a targeted manner. The information from the GG&GD about the health of the population in the neighbourhood provides a good starting point.[58]

GPs can make an important contribution to prevention by motivating patients to engage in preventive activities and referring them accordingly. These activities include ones in the area of promoting a healthy lifestyle and exercise.[59]
Cooperation with other health care providers in the primary care system (such as physical therapists and the district nursing service) and local authorities (such as the GGD [area health authority] and neighbourhood centres) are an essential prerequisite for this.

In addition to the individual care questions, the GP also takes into account the societal dimension of health care. The GP is co-responsible for optimising the use of health care facilities and ensures – in cooperation with the other disciplines in health care – that those with the greatest need receive the greatest care ('equity': the equality principle).[60]

4.4 The 'patient-oriented' core value in parts of general practice care/family medicine

Three-quarters of children go see the GP at least once per year. Fifteen percent of patient contact is comprised of contact with children. This contact provides an excellent opportunity for the GP to fulfil the role of family doctor. The strength of the GP is that in addition to having medical knowledge about the child he also has knowledge of the family and living environment. And the child can see the same GP after reaching adulthood.[61] The Position Paper on General Practice Care and Youths discusses the role that the GP fulfils in providing care for the child and the family, paying attention to the cooperation with paediatricians and child welfare agencies, among other things.[62]

The elderly have above-average contact with the GP, who also makes more frequent house calls to them. Context knowledge plays a major role in this care. The Position Paper on General Practice Medicine for the Elderly discusses this more in depth.[63]

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[57] Social determinants of health. World Health Organization (WHO), 2010. http://www.who.int/social_determinants/en/
[58] Meuwissen LE. et al. Hoe te komen tot een populatiegerichte huisartsenzorg? (How to arrive at population-oriented general practice care?) TSG 2010;88(7):381-387.
[59] Some examples are Bigmove www.bigmove.nu and Beweegkuur www.beweegkuur.nl.
[60] The discipline of general practice/family medicine, general practice care and the general practice facility. Utrecht: NHG/LHV,2003.
[61] De Wit J, Berger MY, Bindels PJE. Primary curative care does not belong at the paedeatrician's. Medisch Contact 2010;40:2082-84.
[62] NHG Position Paper on General Practice Care and Youths. Utrecht: NHG, 2008.
[63] NHG Position Paper on General Practice Medicine for the Elderly. Utrecht: NHG, 2007.

Individual-oriented care is essential in palliative care. Every death is a unique process. The GP takes into account the patient's somatic, psychological, social and spiritual care needs during the palliative and terminal phases.[64]

When caring for patients with a chronic disorder, the patient-oriented approach is a crucial factor in view of (long-term) treatment and support. The GP focuses on recovery/maintenance of functionality, the ability to live independently and perceived quality of life.[65]

4.5 The 'patient-oriented' core value in practice

1. The GP takes into account the patient's individual characteristics and his context, such as his living and work environments and family circumstances.
2. He records relevant, objective information about the family/cohabitation relationship and the occurrence of hereditary and chronic disorders within the family in a 'family information list' that needs to be created.
3. The GP is responsible for ensuring that adequate help is offered to people who are not adequately able to request this help themselves.
4. The GP informs the patients of the importance of the members of his family/cohabitation relationship being registered with the same GP (practice).
5. Information about the patient's context is accessible to the GPs acting replacement.
6. The GP also has the task of calling attention to (impending) work-related health problems and works together with the company doctor when necessary.
7. The GP takes the principle of equality into account: he strives to provide the most care to those who have the greatest need for care.
8. The GP calls attention to situations in the neighbourhood that could be a detriment to the health of his patient population and reports these to the responsible agencies such as the local council.
9. The GP focuses on situations in the neighbourhood that could be a detriment to the health of vulnerable groups, such as the lonely elderly and unemployed youths.
10. The GP is open to cooperating in prevention programmes in the neighbourhood.

[64] NHG Position Paper on the General Practitioner and Palliative Care. Utrecht: NHG, 2009.
[65] NHG Position Paper on the Care of Patients with a Frequently Occurring Chronic Illness. Utrecht: NHG, 2005.

5. GENERAL PRACTICE MEDICINE IS CONTINUOUS

General practice medical care is continuous care. This means that the GP is the one constant factor in health care for the patient. He ensures continuity of care during periods of illness and during the patient's general course of life. The GP works together with other health care providers through his directional role for cohesion in health care.

Continuity of general practice medical care is guaranteed 24/7. The general practice provides personal continuity to the greatest extent possible, with a steady GP-patient relationship over the course of time. The responsible GP ensures cohesion in care if several health care providers are involved in the patient's care. Cooperation agreements and management of the electronic patient file play an important role in this regard.

5.1 Accessibility and availability

Direct access to the GP is necessary in order to offer primary care for health problems. This means that the GP must be located in the patient's geographic vicinity, impose no financial restrictions and be easily accessible and reachable without the patient being referred by third parties.[66]
The general practice is open and can be reached over the phone on weekdays between 8:00 AM and 5:00 PM.[67]Outside of office hours, care is focused on patients with acute symptoms or disorders.[68] It is important to clearly let the patient know the office hours and how the practice works during the day and during evening, night and weekend duty. The organisation of the general practice care and its triage are aimed at guaranteeing care continuity.

5.2 Personal continuity

An essential prerequisite for personal continuity is for the patient to register under his name and for one GP to be explicitly responsible for the care of individual patients.[69] The effectiveness of the general practice care can be largely attributed to the personal dimension of one's 'own' doctor. Knowledge and experience from prior contacts between the GP and patient can be applied during subsequent episodes of illness or health problems. Thanks to this repeated contact, complaints that appear to be independent of each other can be viewed in relation to each other and be defined. Each contact between the patient and GP is a new 'episode' of a 'serial story', as it were. Thanks to the personal relationship, the patient trusts his GP with issues that would otherwise remain undiscussed. Personal continuity contributes to the patient's trust in his GP. Thanks to this, patients have more positive expectations of the treatment's effect. The possibilities for the GP to be able to anticipate and work on prevention increase.[70,71] Personal continuity is valued by patients. This applies in particular to the elderly, patients with a chronic illness or severely ill patients.[72,73] The relationship that the GP has

[66] The strong position of the Dutch GP can be largely attributed to his good accessibility, both geographically as well as financially. The average distance the patient has to travel to his GPs office is 2.6 kilometres. LINH figures: How 'community based' does the GP work? Huisarts Wet 2006;49:293.
[67] If the practice is open until 5:00 PM, the reachability between 5:00 PM and 6:00 PM must be well-organised, e.g. by making solid agreements with the after-hours doctor's offices. See: Guidelines for reachability and availability of the general practice facility. Utrecht: LHV, 2008.
[68] Standpunt De huisartsgeneeskundige inbreng in de acute ketenzorg. (Position Paper: The general practice//family medicine contribution to the acute chain of care.) Utrecht: NHG, 2005.
[69] This principle is especially important when patients are not registered in the name of the GP but in the name of the general practice.
[70] Van Dulmen AM. De helende werking van het arts-patiënt contact. (The healing effect of the doctor-patient contact.) Huisarts Wet 2001 (41)1:490-4.
[71] Pareira D. et al. Towards a theory of continuity of care. Journal of Royal Society of Medicine. Vol 96, 2003.
[72] Schers HJ. Continuity of care in general practice. Exploring the balance between personal and informational continuity. [Dissertation] Nijmegen: Radboud University, 2004.
[73] Meyboom-de Jong B. Continuïteit van zorg voor chronisch zieken. Hersenschim of realiteit? (Continuity of care for chronic illnesses. Fantasy or reality?) Huisarts Wet 2006;8:430-1.

built with his patient throughout the years allows him to offer customised care for complex problems and during the palliative phase.[74,75] The long-term relationship between the GP and the patient has therapeutic value. This aspect is lost if the patient switches GPs often, even with good electronic reporting and even if the principle of one episode, one GP is followed.

5.3 Team continuity

Of course, personal continuity is not always possible, or sometimes the patient does not opt for this himself. In these cases, the team at the general practice can guarantee the continuity of care at all times.
Clear communication about presence and absence clarifies what the patient can expect from his own GP in regard to availability. Modern digital means of communication offer good possibilities of guaranteeing personal continuity to the greatest extent possible, even in the event of limited presence in the practice. The general practice ensures the least possible fragmentation in care. This means that the patient has to deal with a limited amount of colleague GPs when his own GP is absent.

Essential for the general practice team to be able to deliver continuity in care (team continuity) is mutual agreement about the policy to be implemented and good use and administration of the patient file by all members of the team at the general practice facility. The GP ensures that his colleagues can take over care through reporting based on the NHG Guideline 'Adequate documentation with the electronic patient file (ADEPD).' In addition to medical information, relevant background information for the patient is also documented.

After receiving consent from the patient, the GP ensures proper transfer of the patient file if a patient registers with a different GP/general practice.

Task delegation

GPs are increasingly delegating more tasks to other member of the general practice team. The practice assistant executes simple medical procedures that can be easily documented. Practice assistants and nurse practitioners ensure well-documented monitoring, support, counselling and education for specific patient groups after the GP has diagnosed the patient and answered his questions.[76] This keeps general practice medical care accessible to all people, even in the face of changing and increasing health care demand. The growing health care demand is mainly the consequence of the increasing number of patients with a chronic illness. Task delegation is at the expense of personal continuity with one's own GP. Nevertheless, the continuity of care within the general practice has, on balance, increased due to this, in particular because the patient with a frequently occurring chronic disorder such as diabetes mellitus, asthma and COPD can stay with his own general practice for his care and no longer needs to go to the hospital. The GP is ultimately responsible for the delegated care.

5.4 Unified care

The GP has the most complete patient file in health care. Thanks to this he has all the patient's information that is necessary to fulfil the key role in care. He also has an overview of all areas of health care, which allows him to refer the patient in a targeted manner. The GP is the most important referrer for all specialists and allied health professionals. The GP refers patients to a large variety of allied health professionals, specialists and subspecialists.[77]

The GP monitors and promotes the provision of suitable and unified care. He integrates and coordinates the total medical care regarding the patient and is responsible for a unified whole. This function becomes more important the more various health care providers are involved in a patient's

[74] Stange KC, The Generalist approach. Ann Fam Med 2009:198-203.
[75] Stange KC, The problem of fragmentation and the need for solutions. Ann Fam Med 2009;7:100-103.
[76] For more information on this subject, refer to the Position Paper on the (supporting) team at the general practice facility. Utrecht: NHG, 2011.
[77] De Bakker DH. Naar een sterke eerstelijn: specialisatie in generalistenland? (Towards stronger primary care: specialisation in generalist territory?) Lecture on 18 September 2009, University of Tilburg.

care. And this is happening more frequently due to increasing specialisation and subspecialisation. This results in (increased) risks of over-treatment and unsafe situations and increased costs. A consistent, unified, patient-oriented approach by all health care providers involved in the patient's care not only leads to greater patient satisfaction and more therapy loyalty but also to more effective care (including fewer lab tests, less consultation time, fewer hospital stays).[78,79]In view of unified care, the GP makes cooperation agreements with other health care providers when necessary. The GP is co-responsible for unified care in a multidisciplinary team (as is the case, for example, with the care of older patients with complex problems).[80]

General practice medical care and specialised secondary care complement each other. The basic principle here is that the patient can go to the general practice in his neighbourhood and is referred to the hospital when this is necessary. The patient must be able to assume that the GP, specialist and other health care providers communicate clearly with each other and work together well. Given his position and responsibility in health care, the GP invests in his relationships with other health care providers in the primary and secondary health care system. Personal familiarity promotes cooperation between the GP and other health care providers.[81]

Good cooperation means making clear agreements about referrals, transfer of (medication) information and back-referral of patients. The multidisciplinary guidelines, National Transmural Agreements (Landelijke Transmurale Afspraken, LTAs) and National Primary Health Care System Cooperation Agreements (Landelijke Eerstelijns Samenwerkingsafspraken, LESAs), which are based on national and multidisciplinary guidelines, offer assistance in making cooperation agreements at the local level.

The cooperation between GPs and specialists at the hospital can be strengthened through mutual harmonisation of the GPs' and specialists' guidelines and by making agreements about the mutual consultation and provision of advice, over the telephone or with the aid of modern electronic means of communication. To this end, the general practice must be easily reachable (over the phone and/or digitally) for consultation with colleagues.

The GP plays a central role in the coordination of care and information provision. He ensures relevant patient information and adequate information management in the electronic patient file. The GP documents any relevant care provided to the patient by other health care providers with the help of the medical information that is supplied to the GP by these providers. The quality of the electronic GP file is determined by reciprocity. The GP informs other health care providers and they in turn inform the GP in due time, adequately and electronically about the care they have provided the GPs patient. Regional agreements are made about this based on national guidelines.[82] The GP makes a selection of relevant information from electronic GP files available to colleague GPs and triage assistants for the benefit of services.

5.5 The 'continuous' core value in parts of general practice care

There are situations where personal continuity is of extra importance. This applies in particular to palliative care.[83] The GP aims for the greatest possible personal continuity, especially in the terminal phase. The GP ensures adequate and timely transfer to the after-hours doctor's offices in the event that

[78] McMurchy D. What are the critical attributes and benefits of a high-quality primary healthcare system? Canadian Health Services Research Foundation. Canada, 2009 (www.chsrf.ca)
[79] Starfield et al, J Ambul Care Manage 2009;32:216-25.
[80] NHG Position Paper: General practice medicine for the elderly. Utrecht: NHG, 2007.
[81] Berendse, A. Samenwerking tussen huisarts en specialist – Wat vinden de patiënten en de dokters? (Cooperation between the GP and specialist – What do the patients and doctors think?) [Dissertation] University of Groningen, 2009.
[82] Guideline on Information exchange between GPs and specialists in regard to referrals (HASP). Utrecht: NHG, 2008.
[83] NHG Position Paper on the General Practitioner and Palliative Care. Utrecht: NHG, 2009.

he and his colleagues at the practice (GPs under one roof, HOED) or the GP group (HAGRO) are unexpectedly unavailable.

Nowadays, care for frequently occurring chronic disorders primarily takes place within general practice/family medicine. The entrenchment of chronic care in general practice medical care is to the benefit and continuity of care. The GP continues to see the patient with a chronic disorder at least once per year, among other things for an evaluation of long-term use of the patient's medications.[84] Practice has shown that the GP also often sees these patients for health issues not specifically related to the chronic disorder.[85]
The electronic GP file (H-EPD) is indispensable for continuity in care. The Position Paper on the electronic GP file discusses information collection and information administration in more detail with indispensible guidelines for documentation and information exchange.[86]

5.6 The 'continuous' core value in practice

1. Patients are registered by name with a GP at the general practice. The GP feels responsible for his patients.

2. The GP makes an effort to achieve personal continuity. This means that he is present at the practice at least three weekdays per week and communicates this clearly to his patients. The practice assistants keep this in mind as much as possible when scheduling appointments.

3. The GP uses electronic means of communication in order to achieve personal continuity.

4. It is recommended for a patient to only deal with a maximum of two different GPs within a general practice.

5. If personal continuity is not feasible, then the general practice team will ensure continuity of care. Mutual agreement about the policy to be pursued and good use and management of the patient file by all team members of the general practice facility are indispensible requirements for this.

6. The GP evaluates the patient's long-term use of medications at least once per year during one-on-one check-ups.

7. The GP integrates and coordinates the whole of medical and allied health care in regard to the patient and thus directs the patient's unified care. The GP retains this directorial role when he transfers the patient to a medical specialist at a hospital for care during a specific phase.

8. The GP is co-responsible for unified care in a multidisciplinary team, as is the case, for example, with the care of older patients with complex problems. The GP fulfils a medical directorial role as a sort of overseer of his patient's medical care.

9. The GP makes an additional effort for personal continuity when it comes to patients in a palliative or terminal phase.

10. The general practice is open and available over the phone from 8:00 AM to 5:00 PM on weekdays.

[84]NHG Position Paper on Mental Health Care in General Practice Care. Utrecht: NHG, 2006.
[85] Dijk van C, Verheij R. Integrale bekostiging dekt fractie zorg. (Integral cost defrayal covers a fraction of care.) Huisarts Wet 2010;6:299.
[86] Position Paper: The electronic GP file (H-EPD). Information collection and information administration. Utrecht: NHG/LHV, 2010.

11. The general practice informs the patient about office hours and the way the practice works during the day and during evening, night and weekend duty.

12. For the purpose of care provided by other services, the GP makes a selection of relevant information from the electronic GP file available 24/7 to colleague GPs (services) as well as to the emergency room, ambulance service and urgent care facility. Regional cooperation agreements within urgent care are a condition for this.[87]

13. The GP invests in relationships with other health care providers and makes local cooperation agreements whereby he can make use of the national primary care system or transmural cooperation agreements.

[87] Position Paper: The electronic GP file (H-EPD).Utrecht: NHG/LHV,2010

6. OVERVIEW OF CORE VALUES IN PRACTICE

The 'generalist' core value in practice

1. The GP has the knowledge to make a diagnosis for the 400 most frequently occurring disorders and the 80 most frequently occurring complaints.

2. The GP also recognises the complaints and symptoms of less frequently occurring disorders.

3. Thanks to his knowledge of his patient's context, he is able to weigh the predictive value of complaints and symptoms and to recognise symptoms with a possibly serious origin and to discern the patient's fear thereof.

4. The GP works in a cross-disciplinary manner and bases his actions on the principles of evidence-based medicine to the greatest extent possible. He possesses an extensive arsenal of treatments, varying from the wait-and-see policy, evidence-based pharmacotherapy, conversation techniques to (small) surgical procedures.

5. The GP is familiar with therapy for frequently occurring and complex health problems, certainly to the extent that these are described in the NHG Standards.

6. The GP is able to provide information about most disorders to the patient in regard to the expected course of the illness as well as to advise the patient and, if necessary, propose a wait-and-see approach for 'self-limiting' disorders.

7. The GP applies prevention at the individual level by influencing risk factors based on the available guidelines. He is also involved in vaccinations and early diagnosis within the scope of medical screening.

8. The GP is capable of dealing with patients with multimorbidity and polypharmacy. He involves the patient in setting priorities in regard to diagnosis and treatment, taking into account the consequences in terms of the expected benefits and side effects.

9. The GP possesses the attitude and communication skills to respectfully and adequately communicate with the patient, regardless of the patient's age, gender, social-cultural background and cognitive and sensory limitations.

10. The GP maintains his generalist knowledge and skills by means of multifaceted further education/additional training.

11. The GP actively develops his own skills in the area of professionalism, communication and cooperation by participating in peer review, supervision or coaching.

The 'patient-oriented' core value in practice

1. The GP takes into account the patient's individual characteristics and his context, such as his living and work environments and family circumstances.

2. He records relevant, objective information about the family/cohabitation relationship and the occurrence of hereditary and chronic disorders within the family in a 'family information list' that needs to be created.

3. The GP is responsible for ensuring that adequate help is offered to people who are not adequately able to request this help themselves.

4. The GP informs the patients of the importance of the members of his family/cohabitation relationship being registered with the same GP (practice).

5. Information about the patient's context is accessible to the GPs acting replacement.

6. The GP also has the task of calling attention to (impending) work-related health problems and works together with the company doctor when necessary.

7. The GP takes the principle of equality into account: he strives to provide the most care to those who have the greatest need for care.

8. The GP calls attention to situations in the neighbourhood that could be a detriment to the health of his patient population and reports these to the responsible agencies such as the local council.

9. The GP focuses on situations in the neighbourhood that could be a detriment to the health of vulnerable groups, such as the lonely elderly and unemployed youths.

10. The GP is open to cooperating in prevention programmes in the neighbourhood.

The 'continuous' core value in practice

1. Patients are registered by name with a GP at the general practice. The GP feels responsible for his patients.

2. The GP makes an effort to achieve personal continuity. This means that he is present at the practice at least three weekdays per week and communicates this clearly to his patients. The practice assistants keep this in mind when scheduling appointments.

3. The GP uses electronic means of communication in order to achieve personal continuity.

4. It is recommended for a patient to only deal with a maximum of two different GPs within a general practice.

5. If personal continuity is not feasible, then the general practice team will ensure continuity of care. Mutual agreement about the policy to be pursued and good use and management of the patient file by all team members of the general practice facility are indispensible requirements for this.

6. The GP evaluates the patient's long-term use of medications at least once per year during one-on-one check-ups.

7. The GP integrates and coordinates the whole of medical and allied health care in regard to the patient and thus directs the patient's unified care. The GP retains this directorial role when he transfers the patient to a medical specialist at a hospital for care during a specific phase.

8. The GP is co-responsible for unified care in a multidisciplinary team, as is the case, for example, with the care of older patients with complex problems. The GP fulfils a medical directorial role as a sort of overseer of his patient's medical care.

9. The GP makes an additional effort for personal continuity when it comes to patients in a palliative or terminal phase.

10. The general practice is open and available over the phone from 8:00 AM to 5:00 PM on weekdays.

11. The general practice informs the patient about office hours and the way the practice works during the day and during evening, night and weekend duty.

12. For the purpose of care provided by other services, the GP makes a selection of relevant information from the electronic GP file available 24/7 to colleague GPs (services) as well as to the emergency room, ambulance service and urgent care facility. Regional cooperation agreements within urgent care are a condition for this.

13. The GP invests in relationships with other health care providers and makes local cooperation agreements whereby he can make use of the national primary care system or transmural cooperation agreements.

Appendix I

Overview of the Future Vision of General Practice Care 2012 and its elaboration in Position Papers

Future Vision of General Practice Care 2012 (NHG/LHV, 2002)
(medium-term vision of general practice care development)

General Practice Medicine and the General Practice Facility

(NHG/LHV, 2003)

(Concretisation of the future vision with a description of the characteristics of the discipline of general practice/family medicine and the general practice facility)

Elaboration into Position Papers and Advice

- Supporting personnel at the general practice facility (2005)
- Care of patients with a frequently occurring chronic illness (2005) (diabetes mellitus, asthma/COPD, cardiovascular risk management)
- The contribution of general practice/family medicine in the acute chain of care (2005)
- Pharmacotherapy policy in general practice care (2006)
- Mental health care in general practice care (2007)
- General practice medical care for the elderly (2007)
- General practice care and youths (2008)
- The general practitioner and palliative care (2009)
- The electronic GP file (H-EPD) (2010)

- Advice for the general practitioner and physicians for people with intellectual disabilities
- General practice care for military personnel and veterans
- Medical assistance for accidents and catastrophes
- Patient safety in general practice care
- Complex support at nursing homes and in the home
- Practice assistant – competence profile and final attainment levels
- The GP-district nurse relationship
- Cooperation between the GP and youth health care
- Lifestyle and exercise in the primary health care system
- Check code use for child abuse
- Observers at the station
- Selecting a different GP – for the patient and GP

Appendix II European definition of general practice/family medicine

- General practice medicine is normally the first medical point of contact in health care with free and unlimited access and provides initial assistance for all health problems regardless of the patient's age, gender or any other characteristic.
- General practice care stimulates efficient use of the financial means for health care by coordinating care, working together with other professionals in the primary health care system, fulfilling a key role in relation to other specialties and assuming the role of trusted advisor for the patient where necessary.
- General practice care employs an patient-oriented approach, focused on the person, his/her family and the living environment.
- General practice care makes use of a unique consulting programme, aimed at building a long-term relationship thanks to effective doctor-patient communication.
- General practice care guarantees continuity of care during the patient's entire life, tailored to the patient's needs.
- General practice care applies its own operational-research-based procedures prompted by the prevalence and incidence of illness amongst the population.
- General practice care tackles both acute and chronic health problems of individual patients.
- General practice care entails treating disorders that present themselves in an undifferentiated manner at the early stage of their development and that can require direct intervention.
- General practice care promotes health and wellness through both adequate and effective interventions.
- General practice care has a specific responsibility for the health of the community.
- General practice care takes into account all physical, psychological, social and cultural dimensions of health problems, including the manner in which people attribute meaning to life, illness and death.

Appendix III Materialization

In February 2010 a work group started developing this Position Paper on the Core Values of General Ppractice/Family Medicine (previously: Generalist Care). The work group met 10 times and consisted of the following members:

- Dr. F.G. Schellevis, professor at the General Practice Medicine department of the Free University Medical Center Amsterdam/head of the NIVEL research department, chair
- Dr. P. Bindels, GP, professor at the General Practice Medicine department of the Erasmus MC, Rotterdam, chair of the NHG Board of Members
- Ms. C.M.M. Emaus, GP / Generation Next, member of the NHG Board of Members
- Dr. H.G.L.M. Grundmeijer, GP, head of the general practice/family medicine basic curriculum, UvA
  Ms. A.C. Littooij, GP, De Vrije Huisarts
- Dr. M. de Meij, GP, member of the NHG Board of Members
  Dr. M.E.T.C. van den Muijsenbergh, GP, primary health care system medicine, UMC St Radboud Nijmegen
- C.F.H. Rosmalen, GP, head of the LHV Policy and Development department
- Dr. H.J. Schers, GP, primary health care system medicine, MC St Radboud Nijmegen
- Dr. A. ter Brugge, senior policy adviser NHG, secretary
- Ms. C.C.S. Festen, senior policy adviser NHG, secretary

Materialization

During the preparatory phase the work group used external contributions that were provided during various meetings. On 1 April 2010, the basic principles for the Position Paper were discussed during the IOH days with the general practice/family medicine professors and with the heads and staff members of general practice education programs. On 10 June 2010, preparation of the Position Paper was the focus during the NHG symposium ‘The added value of the generalist’ (De meerwaarde van de generalist).
On 3 March 2011, the NHG Board of Members gave its comments on a draft version of the Position Paper.
A draft version of the Position Paper was submitted to the supporters in a feedback round in April 2011. The work group received 30 comments, which were appreciatively used for putting together the definitive text.
Comments were received from, among others, the National Organisation of General Practitioners in Training (Landelijke Organisatie van Aspirant Huisartsen, LOVAH), the university general practitioner institutes, the Association of Private-Practice General Practitioners (Vereniging van Praktijkhoudende Huisartsen, VPH), members of expert groups, members of former work groups that prepared earlier Position Papers and individual NHG members.

Position Paper

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