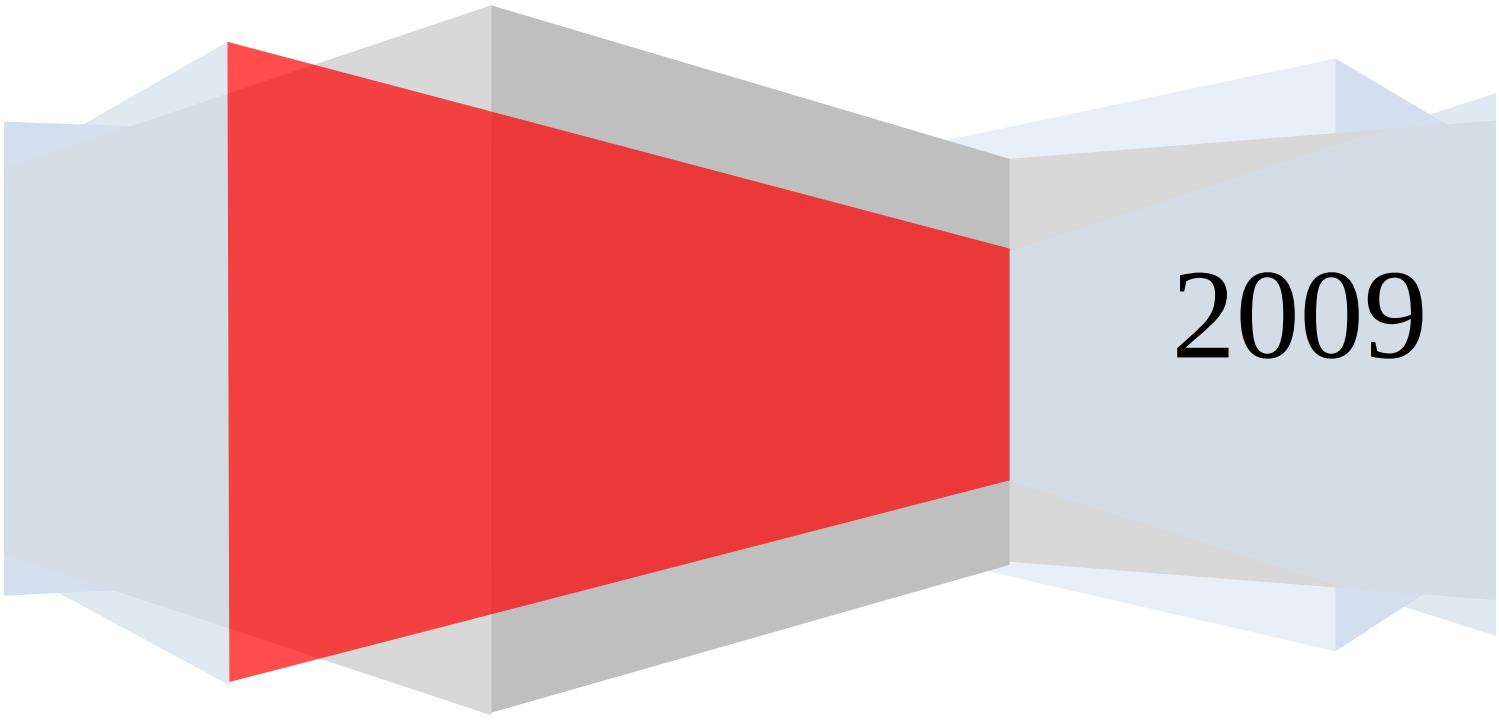
Speciality Training for General Practice in Germany

A Report by a Panel of Invited International Experts.

Commissioned by the
German College of General Practitioners and Family Physicians (DEGAM)



REPORT ON

SPECIALITY TRAINING FOR GENERAL PRACTICE

IN GERMANY

By a Panel of Invited International Experts
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2009

Executive summary and recommendations

Summary of the main points from interviewing key informants

1) The image of General Practitioners is relatively poor in the German system compared with the rest of Western Europe. There is a lack of prestige attached to being a GP. This pervades the system, influencing recruitment, retention and education. Respect for general practice and workforce management are fundamental in terms of making progress.
2) The German health care system does not support a central role for the GP. In Germany the GP does not function as a gatekeeper to the specialist/hospital-healthcare system. There is free access to, and competition with, ambulatory specialist care.
3) There is a funding gap between trainees in GP and trainees in other specialisms which needs to be urgently addressed otherwise there will be a numbers gap with insufficient trainees coming through for general practice. The existing funding system has evolved historically and organically. Evidently the flow of money could be an important driver in the system.
4) Trainees have enthusiasm and values which are not being fostered or capitalised upon.
5) Vocational Training Schemes with guaranteed posts are needed to address the looming recruitment gap and provide secure career prospects and fill regional posts.
6) The curriculum for GP training is not standardised: the end-stage competencies for a fully trained GP should be well described and well-known to trainees and trainers alike.
7) There is no training for GP trainers. Selection of trainers is largely formal. Vocational training in general seems to be dominated by political instead of educational considerations.
8) Trainees have no formative assessment which is not conducive to learning and also the summative assessment requires revision to be more in line with speciality needs of GP.
9) There are enthusiastic trainers of GP. However, they are not well supported and hardly have a voice in the Ärztekammer. Attempts to improve the situation are all too often frustrated by competing interests, e.g. other specialties, or for political reasons.
10) E-learning seems to be developing in some parts of Germany. It cannot provide a solution in itself without the above measures being adopted. Also for the broad curriculum of general practice, the necessity for contextualisation of subject matter and the emphasis on “soft” skills, blended learning provides a better approach. Web-based solutions can be useful for tracking training and assessment.

Comparison of German training for general practice with EU Best Practice

The length of the training period in Germany is 5 years and this is consistent with best EU standards, so in theory the possibility of good training for general practice exists. However in our view the opportunities are not fully used. We detail the relevant standard and the current gap in Germany below (in italics).

The best EU standard of GP-training will include the following:

1) The training programme for general practice is described by the speciality of general practitioners themselves, and recognized by the other stakeholders in the health care system.
Currently in Germany representatives of other specialities form the majority in the Doctor's Chamber and hold sway in this domain, they therefore have the power to specify training in a branch of practice which is not familiar to them. This makes no sense: GPs need to be recognised as equal to specialists and to have their own power of self determination.

2) National training programmes for general practice are based on a curriculum/blueprint of the speciality made by the speciality and using the "European definition of GP/FM" made by WONCA Europe/EURACT as their basis.
We saw little evidence that an awareness of this EU consensus initiative which was completed in 2005 has been integrated into the development of training for GPs of the future in Germany.

3) The curriculum/blueprint for General Practice Training describes the necessary competencies a future GP should master, together with a description of learning and assessment methods.
There seemed to be no overarching blueprint, but a list of competencies that trainees needed to sign off on a regular basis. most of these competencies were technical e.g. ultrasound and to an outsider working in a different EU health system they seemed to bear little relation to the holistic patient centered generalist curriculum of a general practitioner, they also changed relatively frequently and seemed to contribute little to generating an appropriate value base for GP trainees.

4) The training programme is tailored to meet the educational needs of future GPs - that is training posts in GP and in hospitals should meet specified learning needs for GP trainees.
There appears to be little distinction between young doctors in training for a speciality and those training for general practice e.g. they seem to have parallel hospital posts when the experience and learning they require for each speciality differs appreciably and should be tailored accordingly. There seems to be a lack of recognition that GPs need these training posts to become appropriately trained.

5) Abroad the future GP specialist is primarily trained in General Practice where GP patients are seen - so at least half of the training period is used to provide valuable

exposure to General Practice itself.
Again there appears to be very little recognition of the tailoring needed to properly educate a future GP. The majority of the trainees experience should be derived from general practice optimally with exposure to more than a single GP trainer.

6) Training posts in hospitals and in GP should meet specified educational standards (type and number of patients, supervision, feedback etc.) - accreditation of training posts. Training posts should therefore be accredited and re-accredited regularly.
Although there was some evidence of accreditation and review it was significantly less well developed than we note in best practice EU countries. There is usually an extensive framework of regular accreditation and sign off, with internal and external validation, specified frameworks and standards. The situation in Germany is much less well developed.

7) Hospital trainers and GP trainers should meet specified pedagogical standards (e.g. they have participated in trainers courses and meet accreditation standards for trainers).
As above we feel that there is a very well developed "Train the trainers" and accreditation system abroad run by GPs which is significantly under-developed in Germany.

8) Trainers, trainees and training programmes should be supported by local GP educational organisers.
Significant development of educational networks with standards etc as described above occurred when considerable power to develop local programmes was devolved. We see a high degree of different practice in different states generally but little evidence of valuing and utilising this approach to facilitate general practice and underpin its development to have local impact.

9) After entering the training programme the GP trainee should be secured a structured programme and the necessary training posts for the whole training period.
Although there are very few shining examples in Germany on the whole there is no real effort at capturing the obvious enthusiasm of qualifying students for general practice and channelling it into rotations of posts to train for the profession of general practice in particular. This would at a stroke increase the relevance and local application of GP training.

10) Working conditions for trainees should allow a good work/life balance giving a model background for personal and social development - and time for reflection on the trainee's own professional development.
Due to the lack of formal rotations and changing regulations we found that trainee GPs were working under conditions of stress, carried through by their extreme optimism and commitment. In our countries GP trainees have protected time for reflective practice and training and the security of knowing that they are on a structured rotation for a number of years which assists them with planning their lives appropriately.

11) Working and other conditions for GP trainees should be equal to conditions for trainees in other specialities.
There were repeated examples of when GPs were treated as second class relative to those in training to be specialists. There must be a move to recognise general practice as a discipline in its own right with its own values, education and research domain. This has been widely documented and accepted elsewhere.

The status in Germany in 2009 is that GP training does not meet the above criteria (1-11).

Recommendations

1) Reposition the GP in the health care system
2) Regulate competition and unfettered public free access to care
3) Revise salary scales to parity between doctors in training whether they are GPs or specialists
4) Vocational GP-training schemes with guaranteed posts need to be set up
5) Assessment seems relatively undeveloped and appears to need reform.
6) Support for trainers and training practices, not just structural but also educational.
7) Communication skills are a vital component of training for GPs and need to have protected time in the curriculum. A sufficient standard needs to be reached by all trainees.

Given that vocational training fails to meet international standards the role of the Ärztekammer should be questioned. International experience shows that vocational training should be the responsibility of each specialty. At present this is not the case in Germany.

Main Report

Introduction

This report aims to discuss the current state of speciality training for general practice in Germany based on the evidence given to this International Commission from a variety of stakeholders. The commission itself was composed of representatives from Denmark, The Netherlands and The United Kingdom who are experienced in the field of general practice and medical education. We present the evidence from the various perspectives of those with whom we met, and of those who were unable to appear and from whom we sought written information. Each section is followed by a summary of the current state and finally our recommendations for future development based on best practice and examples from our own countries.

Key-Informants

1. Federal Chamber of Physicians (Bundesarztekammer)

In attendance:
Dr Cornelia Goesmann (Vice-President)
Dr Guntert (Head of Training)-unable to attend

Dr Goesmann is in general practice in Hannover with her husband and a colleague. The practice has been established for 24 years. She commented that "its hard, no-one is really interested, no-one really helps the younger doctors"

There have been attempts to address the gap between hospital doctors' salaries and those of GP trainees. There is a big gap between the salary of specialist trainees at 4000 Euros per month and that of GP trainees at 2000 - 2,500 Euros. This will lead to a recruitment crisis. There have also been attempts at negotiating with insurance companies but they were not interested in initiating change. There needs to be a political directive in order for interested parties to change. Most patients identify with a house doctor but there is a tendency to also want access to a specialist. There needs to be a commitment to General Practice in the system.

Recruitment and replacement of retiring doctors is an issue. Cities and towns are relatively well off but there is a looming gap in certain geographical areas e.g. the rural east. There is a reluctance of young people and families to live in rural areas, there is a lack of motivation to go into GP overall, and it is relatively poorly paid. There are 500 GP trainees a year and 2000 are needed. It should take 5 years to train a GP but it looks as if its now taking longer e.g. 6-7 years and this is put down to feminisation of the profession.

There is no regulation on how many students can enter training in the different specialties.
40 % can drop out in speciality training – especially in GP.

It seems difficult to fund 5 sequential guaranteed training years for GP on a rotation. This is due to the pressure of work on GPs, lack of underpinning finances, and no local authority to enact change.

Health Insurance.
An important influence based on trades originally. Competition to drive down usage. Common risk adjustment. Single payment system. 15% of an income goes to Health Insurance and also pays for drugs and therapy.

What would help?

Try to give the students a good impression of GP – image-building of the speciality.

Standardisation of training. GPs should construct the training schemes for GPs (of course) - no other specialists should decide on GPs training scheme.
Need to connect general practice training and hospital training and establish contracts and rotations for training GPs.

Payment – needs to be sufficient throughout training (and equal to payment for trainees in other specialities) and guaranteed e.g. at 4000 Euros, 50% from insurance company and 50% from SPK.

KV needs to start negotiations to broker such an agreement.

Set up local commissions of Ärztekammer, KV, union GPs and the German College of General Practitioners and Family Physicians (DEGAM) e.g. this has happened to some extent in lower Saxony.

They need to budget for sufficient numbers of trainees at a realistic rate of pay.

25% of trainees leave Germany/the system. (Go abroad, work for Pharma or go to management). Specialists seem to have evolved a better work life balance than equivalently experienced GPs. Specialists seem to have more scope for working flexible hours, determining on call arrangements and ensuring regular free time to avoid burn out. They also have a better income from a third more to double that of a GP. They can also have additional private income (partly true also for some GPs). These differences in income are also a negative factor for recruitment of GP trainees.

Training

Basic Medical Education: 5 years plus 1 year of experience, a “practical year”/electives (4 months internal medicine, 4 months surgery, 4 months any other clinical field) at university. Dr Goesmann felt that most doctors do not know exactly what they want to do when they qualify. (However at the University of Goettingen Medical School. The majority of students, asked at the final university ceremony know exactly where they want to go – about 5% to general practice reported from personal experience from a member of the educational committee of that school). Those who would like to be GPs later typically start in internal medicine and then gravitate to general practice. As there is no formal training scheme for GPs most start as internists in hospital specialities. They would do e.g. 2 years of internal medicine and then a small number succeed in getting a paediatric post. In general practice they can stay for up to 3 years, but most choose to stay 2 years. The Ärztekammer and the KV decide if a practice is suitable and

this is on the basis of the patient list, facilities, case mix, activity and visiting list. The Kammer accredits the practice. GPs do not however have to be trained as trainers. There is a yearly requirement that the Trainer and Trainee have protected time to sit down together and discuss training matters but there are no standardised plans for vocational training sessions or a curriculum. (Contrast this with the increasingly sophisticated annual formal appraisal systems in e.g. the UK)Trainees need to work up to 80 hours for the 5 years of training and 2 Saturdays per year on call. In reality it is easy to do 100 hours per week due to the workload. There is no selection process for GP, people self select.

Summary

- Address lack of prestige - there is lesser prestige attached to being a GP and the results of this pervade the system influencing recruitment, retention and education.
- Funding gap - between GP trainees and specialist trainees which needs to be urgently addressed otherwise there will be a numbers gap with insufficient trainees coming through for general practice. There is a tension with the free market principles on which the system of re-imbursement is based however this area is under-regulated and does not serve the purpose of supporting GPs and training. It is evident that in Germany, compared with e.g. the UK, Netherlands and Denmark, the system is dependent on many different players who interact and need to agree in order for change to occur in the field of general practice and GP training. The default option due to the complexity of this picture in Germany is inaction, which would be dangerous in terms of maintaining health care delivery. There is a pressing need to look at the numbers of GPs needed for Germany in the future and then to ensure budgets and funding are aligned with all interested parties coming together to uphold the agreed plan.
- Vocational Training Schemes with guaranteed posts are needed to address the looming recruitment gap and provide security, enhance career prospects and fill regional posts.
- There needs to be more support for teaching in general practices and also Training of Trainers.
- There needs to be more self-determination by GPs e.g. in setting their own standards and examinations.
- Set up local commissions of Doctor’s Chamber, KV, GP’s union, university GPs to work together on the above.

Recommendations

- **Dialogue between stakeholders to reposition GPs in the health care system.**
- **Review of position and responsibilities of Doctor’s Chambers, Sickness Funds, DEGAM, Government.**
- **Revision of salary scales to parity between doctors in training whether they are GPs or specialists**
- **Voctional training schemes with guaranteed posts need to be set up**
- **Support for trainers and training practices, not just structural but also educational**
- **Regulation of competition and unfettered public free access to care**

Examples

NL

In Holland there is a national foundation that serves as the employer of the trainees in GP (SBOH = Stichting Beroeps Opleiding Huisartsen). The money was raised by increasing the insurance premium with a very small percentage. The money is transferred by the Ministry of Health to the SBOH. This way all the money is earmarked for GP vocational training. Trainees are employees of the SBOH-foundation, and are directly paid for the full period of the vocational training. Their salary is comparable to that of trainees in other specialties.

University Departments of GP get a lump sum per group of twelve trainees to pay all costs of Department-initiated training programs (including teacher salaries, cost of train-the-trainer-programs, material costs like rent for housing of the department, etc). The training curriculum for trainees is run on a day release basis, of 1 day a week, for the trainers of 1 day per month. GP training practices get reimbursement of expenses from the same SBOH-foundation for the time they house a trainee.

DK

In Denmark GP as speciality has high prestige among doctors, patients and the politicians. Income in GP is comparable to income in other specialities (or a bit higher on average). This is a good basis for recruiting trainees to GP.

The training period for nearly all specialities is 5 years (coming on top of 6 years student training and 1 year postgraduate basic training). In GP it was 3½ years until 6 years ago – and the lengthening of the training period to 5 years gave the training higher prestige.

All trainees are paid by hospitals or national health insurance – and salaries are equal for all trainees – note: in the last part of the training period for GP trainees part of the salary is paid by the training practice – but the total salary is decided by national agreement for all trainee doctors.

A GP trainee must have ½ year introduction to GP (where he/she decides if GP is the wanted specialty – and the trainer finds out if the trainee is trainable to be a good GP). After successfully finishing this ½ year the trainee must apply for a “training package” of 4½ years duration with specified rotations.

Training practices must be accredited by GP-training coordinators – and the GP-trainers must attend training courses. A training practice must produce a training programme for each trainee and in this programme time and methods for supervision and guidance must be specified. These training programmes must be accepted by the GP-training coordinator.

UK

In 1995 there were 28,869 GPs, and in 2005 35,302.The number of GPs, the Number of GPs has increased by 28.29% in the UK over this period and there was a further 3.57% increase 2004-2005. GPs per 100,000 population were recorded for 1997 as 58%, for 2005 as 65%. (80%were UK trained, 5%EU, 15% Rest of the world).After recent reforms GPs in the UK have been reported to be the highest earning in Europe(£110,000 per annum average if full time 8-10 half day sessions per week), their income being comparable to specialist consultants. There are concerns however with increasing part-time working (men and women) as full timers increased by only 12%.

After medical school all newly qualified doctors must undergo 2 years of Foundation training in approved specialities developing generic skills) and then 3 years of specialist training e.g. in General Practice.(24 months in a hospital setting and at least 12 months in GP). Selection is national but potential recruits apply for a place in the Deanery (locality/region) of their choice. Training programmes are organised and accredited through regional Postgraduate Deaneries based on a common curriculum.

In the most junior post (Foundation year 1) a doctor would earn a basic salary of £20,741. This would increase in the second year (Foundation year 2) to £25,882. A doctor in specialist training could earn from £29,000 to £44,000.
In addition a doctor in training would be paid a banding supplement determined by:

- the amount of hours worked over forty hours a week
- the intensity of a doctors workload
- the amount of work carried out at unsocial times

Banding supplements pay 20% to 80% of the basic salary. The most common supplement paid is 50%. A typical doctor, five years after graduating form medical school, on a 50% banding supplement would be earning approximately £48,000. The payment system is similar to Denmark with nationally agreed scales and a standard split when the trainee is working for the GP in the GP practice. Trainers are also paid for training new GPs on an agreed scale. Deanery approval is needed and there are local course organisers appointed to ensure the system works at a local level.

2. The Trainees

In attendance:
Christian Haffner, Frankfurt/M.
Marcus Schmidt, Tengen
Susanne Schumann, Berlin
Marco Roos, Heidelberg
Verena Dicke; Berlin
Susanne Pruskil, Berlin
and:
Stephanie Joos, GP in Heidelberg
Thomas Lichte, GP, Professor, DEGAM

The trainees had prepared a power-point (About the Fiasco of German Vocational Training in General Practice) by way of personal appraisal (included as an appendix), their views were not only based on personal experience but also this meeting followed a visit to The Netherlands and dialogue with GP Trainees from all over Europe.

There is no standard GP training so trainees must pursue their own jobs which are difficult to obtain e.g. paediatrics as they may be ringed fenced for paediatricians. Internal medicine jobs may also be highly specialised e.g. in renal medicine - is this of value for a generalist? They can work up to 80 hours a week in hospitals, often in such highly specialised jobs which have little direct relevance to patient care as a GP. This compares with communication skills which the trainees recognise as vital, but they only get 10 hours communication skills training in 5 years. (80 hours of a course of psychosomatics which is divided into 3 parts: 40 hours psychosomatic medicine, 10 hours communication skills, 30 hours Balint group).

There are also many regulations which they need to fulfil e.g. they have to perform 500 ECGs and get this signed off. Again it is difficult to see the direct relevance of this emphasis on technical skills. The Doctor's Chamber approves rules but they need to be more aware of the impact these rules have on the vocational training of GPs. Payment scales between hospital specialists in training and GPs are vastly different, and should the GP trainee fail to arrange their next job the unemployment benefit is not enough to live on, so there is a great deal of pressure to keep finding the next job.

Given these adverse circumstances we asked the trainees about their motivation: given these, why they had chosen general practice?

They were articulate in valuing a holistic approach to medicine, they wanted to work close to the patient, they valued the variety (of patient problems and of jobs), they enjoyed the community aspect, they wanted the freedom of having their own practice, and the autonomy of working, and lastly they had experienced positive role models.

Finances

Some rural Länder may attract trainees by giving them relatively more support, so they can offer trainees a vocational training scheme with guaranteed pots but then the trainee needs to stay in that Land.

Overall if you are working in a hospital post it pays to sign up as a trainee specialist doctor rather than a General Practice as the contract is more favourable as e.g. an internist.

Hospital posts are paid at 3-4,000 Euros per month, GP at 2000 (in West Saxony and Hessen it can be higher 2-3.500 but the workload is also higher). Where does the difference in funding go? It is unclear where the block is between the KV, the Doctors' Chambers and the trainers. A top up is needed to make the trainee salary comparable. Currently the DKG gives 1000 Euros per month to the hospitals for training and the KV 1-2000 to GP in the training practices, but this is not always filtering through to the trainees who remain lowly paid compared with their peers in hospital. There is a model in Thüringen where trainees are supported to get through their vocational training and become local GPs and their salaries are guaranteed throughout.

Structures

Kammer in each Land, independent, and governs the profession.
KV disburses funds for all ambulatory care (provided by specialists and GPs). and is governed by Hausarzteverband (union). Both organisations have assemblies elected by members and in both GPs are in the minority compared with hospital specialists, thus GPs have relatively less input into decisions. Dominance by internists who would get money and patients taken away from them if general practice proliferated.

Structures are fractionated. It is therefore difficult even for GP trainees themselves to maintain an overview. The doctors' chamber is dominated by internists and is not perceived as being sympathetic to the development of Primary Care. There needs to be recognition of specialists in the ambulatory sector.

Training curriculum

This is a voluntary extra run on a day release basis, of 1 day a month (compare this with regular protected learning time and weekly day release schemes in e.g. The UK, Netherlands and Denmark). In Heidelberg they have an evening a month of training. In Berlin its Wednesday mornings. There is some communication skills training and also some training on guidelines.

Training in hospitals:

60-80 hours per week. This includes procedures such as doing a sufficient number of Ultrasound examinations. The whole training seems to focus on sufficient experience with 'technology driven' testing, without any awareness of the principles of epidemiology (no scientific underpinning of rational use of tests, pre- and post-test probability of disease, or the meaning of sensitivity and specificity of tests). There are many such examples in the Weiterbildung and there is a tension between doing these procedures and getting signed off for training purposes by superiors, rather than a deeper insight in what and when and why to test. There is no real curriculum. The hospital training is on the job learning in preparation for being an internist, not

customised to GP, and there is little appropriate supervision. DEGAM provides training but there is a feeling that such training should be a result of a bottom up initiative.

Training in General Practice

There is no standardisation. It can be formal or informal. Getting 15 hours per week of supervision and training would be exceptional. The working week is 45 hours per week and one week-end per month on call. In this way the trainee works the same as a real GP for 30 hours, 8-12, then visits, then 14-1800 and sees 20-30 patients per day. One trainee was in an exceptional training practice in Berlin where she has 28 hours per week of work and Friday off for educational purposes, she sees 12 patients per hour. In addition when the trainees stand in for their trainers during holidays then they can see up to 70 patients a day.

Case-mix was mentioned as a problem as old patients like to see their own doctor that they know, not the trainee. Also summer cover and holidays for the trainee was cited as difficult to fit in.

Assessment

There were many and various reports-again there seems to be a lack of a consistent approach, and assessment does not appear to assist learning, rather they are barriers to jump or performance to be signed off.

One comment was that a training practice was geared to being a workhouse not a place of education, in other words the trainee was left alone to see patients from day1 and expected to deal with patients making no mistakes. In other practices operational assessments were made of the trainee's performance or what they did was reviewed on a computer system. Patient satisfaction was used as a measure but the trainees felt that this was a complex indirect measure of their performance.

Trainees are asked to fill in a form about their practice and what it offers: the physical set up, whether they have a separate consulting room, what journals or books they can access and whether they can see a cross section of patients. There is no mention of teaching in this form. Furthermore there are only a few trainers who use this form, the standard is still: no assessment.

Heidelberg appears to have a potential model in that they do have quality assurance procedures in place for training, and train the trainer's courses for undergraduates.

It was felt that there was a place for undergraduate and post graduate training practices to develop in a single practice interested in education. The university departments could then support this network of educational practices and support the teachers on GP also. The government requires each university to offer a rotation in GP. This is 30-50 Euros a day or 500 a month. Here is an opportunity for government with a funding lever to work with academic departments in universities to impact on undergraduate training – could this be extended to the postgraduate sector?

Examination

There is a single summative assessment. The trainee need 5 years minimum of practice to apply for the exam which lasts 30 minutes. Female graduates who have children during this period may in total use 7-8 years to be able to apply for the exam. The exam takes place in the physicians' chamber where there is usually a group of GP examiners and 3 GP examiners construct the exam. Usually this consists of a case report: what would you do? Examine test results e.g. ECG, Ultrasound, therapy and commenting. 2% fail. It is not standardised and there is a benign atmosphere. You do need a formal statement of fitness to practice as a GP. An administrative system exists in the Landes Ärztekammer which has a mandate to check certification etc. Failing the exam seems to have no consequences.

It was felt that Heidelberg is a good model. It is a pilot established by the Ministry but would be possible to disseminate. There are 4 centres in Heidelberg and 2 in Mittel Baden. Originally there was a poorly defined network so they took the opportunity to establish the network for GP education. The Doctors Chambers have the responsibility and the University has the knowledge so there is good opportunity for collaboration locally which would resonate with the ideals of self government that pervade the system in Germany.

GP is not unique with respect to training: there is a general under-development of teaching models and support for teaching.

The trainees' motivation was well grounded in the basic foundations of general practice, however this was not capitalized upon as it was wasted by the seeming lack of development.

Money flows are fractionated and there is evident dis-equilibrium-ring fencing money for the training of all doctors would circumvent some of the power issues and deliver salaries of equitable value to those in training wherever they may be.

No formative/summative assessment that worked

Here is an opportunity for Government with a funding lever to work with academic departments in universities to impact on undergraduate training –could this be extended to the postgraduate sector?

Hausartzeverband gives the impression that no-one is really interested in GP and GP is under-/not represented. This is where DEGAM should act and form a dialogue with Hausartzeverband. There is no financial driver for training; CME-work generates the money. Vocational training needs financial support to make it successful. Morale is consequently low and trainees and GPs feel undervalued and exploited. Prevention, the usual province of primary care e.g. BP measurement or blood glucose measurement is not currently re-imbursed.

There is little emphasis on the doctor-patient relationship or communication and the system feels as if it's been technologically high jacked in terms of where the emphasis lies.

10 hours of doctor-patient communication is given but the trainees have to pay for it themselves. There is a heavy emphasis on psychosomatics and psychotherapists teach communication skills.

Where are the drivers?
Does anyone want primary health care? No?
Patients want unlimited access
The politics are that all persons are insured up to a level, but can opt out if greater to the private sector and also there is support for those with the lowest incomes.

What's in a name? Facharzt fur Allgemeinmedizin.

Summary

- Trainees have enthusiasm and values which are not being fostered or capitalised upon
- No vocational training schemes, so a lot of the trainee's time and effort is spent in gaining employment
- The system of contracts could be amended to support general practice and the experience and educational input should reflect this specialism e.g. balanced emphasis on procedures and communication skills.
- There needs to be a financial reward for trainees to offer sustainability. The financial gap between salaries in GP training and hospitals training is resented and damaging and does not make trainees feel valued.
- Too many regulations which often change and appear to be dislocated from career development and progression in general practice
- There is very little team work – essential for general practice.
- They need to learn to perform a lot of tasks e.g. Ultrasounds which need to be signed off and which do no bear a direct relation to the development of GP expertise
- The curriculum for GP training is not standardised.
- "Train the Trainers" of new GPs is urgently needed.
- There needs to be more emphasis on educational elements – a standardised curriculum and delivery. Elements pertaining to GP such as consultation and communication skills should not be paid for outside the curriculum but should be an integral part of training.
- Trainees have no formative assessment – and is really lacking structured formative assessment
- The summative assessment needs revision to be more in line with speciality needs of GP.

Recommendations:

Selection
Contracts
Curriculum and communication skills are essential
Formative and Summative assessment
Train the Trainers
Remuneration
Local groupings of trainers/educational practices

Examples

DK

In Denmark the blueprint of the speciality GP outlines 119 competencies a specialist in GP should master (theses competencies listed according to 7 different roles a GP should master – "the CANMED roles").

It is decided when each of these 119 competencies should be acquired during the 5 year training period. The GP trainer is together with the trainee responsible for focusing on training of the appropriate competencies during each rotations (and so are the hospital-trainers for the rotations in hospital setting). Formal assessment given during the training – and a final summative assessment given in the workplace setting. So in Denmark there exist no final specialist exam for any specialist training schemes – all assessment is given as "workplace based assessment".

In every local and regional setting the national health insurance system have engaged GPs as part time training coordinators. These training coordinators have during nearly 20 years been a cornerstone in Danish GP training (inspiration came from UK: "course organisers"). The training coordinators are involved in GP training in several ways:

- contact to and inspiration for GP trainers
- giving training courses and meetings for GP trainers
- arranging regularly meetings with the trainees
- teaching trainees
- are a resource for the trainees in many respects
- creating and facilitating networking amongst trainees
- involved in selection process of trainees

There is also a formalised theoretical training programme for GP trainees – run 3 different places in Denmark (in relation to the 3 GP units of our 3 Medical Faculties at the Universities of Copenhagen, Odense and Aarhus).

The Danish College of GPs (DSAM - a pendant to DEGAM) organises the GP-trainees. DSAM has 3300 members – of these are about 750 trainees. The trainees make a special subdivision of DSAM and have special privileges – e.g. 2 places in the board. It is felt very important for the trainees self esteem and adherence to the speciality.

NL

In The Netherlands the vocational training is quite similar to the Denmark blueprint. Main difference is the duration: 3 instead of 5 years. In Holland trainees do only 1 year of hospital-rotations. The whole vocational training is controlled by the university departments. Guideline development is done by the Dutch College of General Practitioners. Guidelines and EBM (Evidence Based Medicine) are the main content of the training during the first year, as well as training in communication skills.

UK

The competences that all new doctors in training for all specialities will be expected to achieve are based on the principles laid out in the GMC's Good Medical Practice (a new version is currently out for consultation):

Good clinical care
Maintaining good medical practice
Relationship with patients & communication
Working with colleagues
Teaching & training
Professional behaviour & probity
Acute care

Additionally the Royal College of GPs has a list of 16 broad areas that trainees must attain competence in, which have more detailed defined objectives that Trainee and Trainer utilise to guide teaching and assessment. This is a web based tool which can be accessed by both parties and updated as the Trainee progresses. There is both Formative and Summative assessment. This e-portfolio records details of achievement, documents all stages of training, and records evidence of Workplace based assessment WPBA and reviews with educational supervisors.

A record of personal development and experience is becoming mandatory for all doctors. It provides evidence that training has taken place and allows the GP trainee to reflect on a range of learning opportunities. The WBPA is defined as the evaluation of a doctor's progress in their performance over time, in those areas of professional practice best tested in the workplace.

Workplace-based assessment brings together teaching, learning and assessment. Trainees will know what is expected of them and will have the opportunity to demonstrate attainment over time in a variety of contexts. The assessment recorded in the e-Portfolio will be drawn from performance and evaluation taking place in the real situations in which doctor's work. It also allows competence in areas such as team-working to be appraised in a manner which cannot be done by the Applied Knowledge Test AKT and the Clinical Skills Assessment CSA.

The Applied Knowledge Test is a summative assessment of the knowledge base that underpins independent general practice in the United Kingdom within the context of the National Health Service. Candidates who pass this assessment will have demonstrated their competence in applying knowledge at a level which is sufficiently high for independent practice. Whilst candidates will be eligible to attempt the AKT at any point during their time in GP specialty training, it is anticipated that the most appropriate point, and that providing the highest chance of success, will be whilst working as a GPSpR in the final year of their specialty training programme (ST3).

The Clinical Skills Assessment (CSA) is an essential component of the nMRCGP, and is 'an assessment of a doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for general practice' GPStRs will be eligible to take the CSA when they are in ST3 (the third and final year of their GP specialty training).The CSA is offered at least three times a year. The assessment centre is located in London and has been created by fitting out three floors of the building specifically for the purpose.

Each candidate is allocated a consulting room and has 13 consultations, each of 10 minutes. Twelve of these are assessed; the 13th is a pilot case. Patients are played by role-players who have been trained and calibrated to perform their role in a consistent manner. Assessors are also trained and calibrated

Regional Deaneries headed by GPs and a network of local course organisers support the system of training. Train the Trainer courses are run locally and trainers need to prepare their practices and themselves for training g and are accredited .Remuneration fro all of these posts is at nationally agreed rates

The Royal College of GPs has been central to the reform of the system and for driving forward standards and agreements.

3. The Sickness Fund

In attendance:
Representatives of AOK
Dr Christian Peters (Medically qualified and responsible for ambulatory care)

AOK is a system of statutory sickness funds; it was founded historically for blue collar workers 125 years ago. The individual AOKs are organised on regional level roughly according to the federal states. More than 25 Million people are insured by the AOK with a 54 Billion € volume of benefits. The market share of the AOK is 35%. The Federal Association of the AOK is the umbrella organisation providing services for the regional AOK, fostering AOK as a common brand and advocating the common health policy of the AOK in the different boards and political bodies.

As of end 2007 there were 120.000 doctors working in private practice, with 48.8% being GPs. Since the reunification of Germany the overall number of physicians has risen by more than 30%, more than 10% within the last 10 years. As of the end of 2007 Germany provides one physician to 261 inhabitants, ten years before the figure was 290 inhabitants. GP numbers are decreasing, 0.6% within the previous year, the same applies however for ophthalmologists, neurologist, obstetricians and gynaecologists and dermatologists. 17.5% of the physicians working in private practice are 60 years or older, so are 11% of ambulatory physicians in general. There is a concern that the number of GPs will fall critically within the coming 5 to 10 years. Apart from the problem of a general elderly population of GPs, there is a relative lack of GPs in some rural areas, especially in the eastern part of Germany. However, the disproportionate regional distribution is even worse when it comes to specialists. The problem of distribution is relative; overall Germany is oversupplied with physicians including GPs.

Due to structural deficits in some rural areas it is far from being attractive for young GPs to settle in rural areas (social life, education possibilities for the children, few privately insured patients etc.). The regional Associations of Statutory Health Insurance Physicians (ASHIP=KV) are trying to attract GPs by minimum income assurance and the provision of buildings free of rent. The effect of this effort is moderate.

In summary: the relative over-aging of physicians must be considered, as this will reduce the relative oversupply of physicians to a normal level, hence the problem of maldistribution will be potentially aggravated. The attraction of clinical work for physicians is generally decreasing while the opportunities on the job market including for training are increasing. In this context it is not very likely that GPs will be attracted to remote areas by educational incentives.

The professional recognition of GP is even poorer than the constantly falling recognition of physicians in general. The public view highlights the successes of specialists, and scandalises the quality of the medical profession as such. However, in the past two to three decades the Board of Physicians (Ärztkammer) has issued various curricula for GP in accordance with the EU-regulation in order to improve the quality of care of the GPs. This includes giving a specialist status to GP (FA für Innere Medizin und Allgemeinmedizin). The German Ministry of Health has tried to re-enforce the situation of the GPs by several initiatives to mention only the following:

- The introduction of a praxis fee of 10 € per quarter of a year in 2004 supported the GP, as the patient has to pay another praxis fee to each specialist if he/she is not formally referred to by a GP.
- The co-financing of the education of GP by the German Hospital Society, the Association of Statutory Health Insurance Physicians and the health insurance funds. This law was recently issued in a new version.
- The obligatory selective contracting of GPs until end of June 2009.

Especially the latter initiative of the MoH already shows the relatively lack of interest of the insurance companies in GP work. The gate-keepers role of the GP is not proven yet in terms of cost-effectiveness and efficiency as a recent study showed again. The special contracts with the GP seem for most of the insurance companies as well as for most of the AOK not attractive but costly. As far as AOK have selectively contracted GP they impose strict quality assurance rules, often based on soft-ware tools, to insure an improvement of quality for the extra money. There is a general lack of confidence in the quality of the GP's work. Even the MoH has issued another law to include the specialists in selective contracting.

Conclusion II: The GPs are in the opinion of most of the AOK not qualified enough to take over a key role as gate-keeper in Germany, even if supported by different legal initiatives. The given structure does not allow the AOK to intervene for the improvement of the curricula of medical education as this is to the Board of Physicians, neither to control the quality which is to the Regional Associations of Statutory Health Insurance Physicians.

The GP's education co-financing is a very controversial issue. Until recently (1999) specialists and GP were looking to gather their specific education in ambulatory care and hospital centres. The decreasing attractivity as mentioned above led to the current situation. As the ambulatory care is under the responsibility of the Association of Statutory Health Insurance Physicians, the problem is mainly theirs. The regional ASHIPs are responsible for the distribution of financial resources to the physicians thus regulating the quote of physicians including GP. The maldistribution of GPs is primarily a failure of the ASHIPs.

The job market for in hospital residents is enormous, so that candidates for GP could easily complete their curriculum. However, the AOKs are forced by law to support financially GP education. Although providing one part of the financial resources, AOK have no influence at all on the curriculum, which is still far behind the European standard, nor on the regional distribution of GP. In addition the hospitals' demand for co-financing is not at its limits. Obviously some hospitals feel more free to recruit their residents under their own conditions on the market. So far, the co-financing was dedicated to the institutions for the augmented workload of education. The aim was to raise the output of GPs. Despite the efforts, the number of physicians who complete the GP-education is still decreasing. Even worse so in remote areas.

This development led to another initiative of the MoH:

- To augment the financing in order to guarantee an adequate salary to the GP-candidates
- In remote areas the salary should be higher to motivate the future GP to stay

- To develop a common concept by the National Association of Statutory Health Insurance Physicians, the German Hospital Society and the representation of the sickness funds including a common fund

Still the legal initiative is without any concept for the distribution of GP which is the task of the Associations of Statutory Health Insurance Physicians. The concept of the head organisation of the sickness funds (GKV-SV) includes a system of conditioned grant with pay-back obligation in case the GP is not opening a consultancy as planned or closing it before due time. However, this could be counterproductive if not a serious draw-back, as this condition is unacceptable for a young GP and his family. At least the financial incentive of 5.000 € would by far not be enough to compensate the social and financial risk for the GP.

Conclusion III The Associations of Statutory Health Insurance Physicians have failed to organise the medical care adequately. Due to effective lobbying the ASHIPs try to increase the statutory sickness funds' share for the co-financing of medical education through the legal initiative, although the new legal regulation for co-financing brings no solution to the disproportionate regional distribution of GP. The co-financing is a mere method and does not even come close to a conception of care. Poor results would not be a surprise.

Key points of safeguarding the provision of remote areas with GP care are:

For GP offices to remain the columns of provision of health care not only the salary but also working conditions must improve. The single GP setting is not optimal. The GP must be online to the high class medicine of the universities, both for quality care provision as well as for professional contact and exchange.

The new contracting law (Vertragsarztrechts Änderungsgesetz), which allows physicians to work in different offices as well as in a hospital should be liberally applied to share the burden of work. Additionally hospitals must be opened for ambulatory care, with satellites in remote areas. Effectiveness of the GP work could be augmented by qualified assistants. The issue of specialist nurses is completely undeveloped in Germany. Telemedicine is rather a marketing item than part of the medical care vocabulary. Again, all this applies to specialists too.

The vision of AOK is to tender medical care for a special region, setting the conditions of care including presence, emergency care, waiting times etc. Every institution able to respond to the tender could bid, including hospitals, medical care centres (MVZ) the Association of Statutory Health Insurance Physicians, management societies or what ever constellation of providers who are able to develop a specific conception. Thus the optimal care could be established and financing would contribute to health system changes rather than for the protection of old idols.

Overview

- In absolute numbers there is no deficit of physicians or especially GPs in Germany
- The Association of Statutory Health Insurance Physicians has failed to fulfil the task of ambulatory health care provision
- The extra educational programme for GPs has failed in the past, there is no reason to assume that an extra 1.000 € will bring the success

- The AOK are not willing to co-finance GPs' education but to co-finance the development of new concepts of care, while taking part in the corresponding decisions
- Due to the falling attractiveness of clinical medicine especially family medicine and the technological development new concepts of care are urgently necessary and appropriate.

Summary

This funding system has evolved historically and organically. Evidently the flow of money could be an important driver in the system. Also the position of the Sickness Funds in the system, such as AOK, means that they are very aware of the current state of play and are powerful potentially, but they do not perceive themselves as having power. The interface of the Sickness Fund with KV and Ärztekammer means that the power potential of the Sickness Fund is effectively undermined. The historical growth of the system means that there are today too many stakeholders and that they are stakeholders in different ways (money, professional power, etc.) with differing agendas.

Enacting a commitment to a GP centred care system would potentially unify these elements behind a single pragmatic and cost effective outcome. Contracts could be revised to support this movement. Vocational training agreements could be included in these contracts. Hauseärzte Verband could make sure that e.g. 5 drs in an area (according to demand) are educated on the Vocational Training Scheme, and the Sickness Fund could support this initiative, in co-operation with DEGAM and the HausartzeVerband. However care needs to be taken not to build another organisation which would add to the parties already mentioned as existing in this structure.

Recommendations:

- The image of GPs is not very good in the German system. Does this imply that better profiling and professionalisation is needed?
- Quality improvement mechanisms need to be put in place for vocational training schemes
- Equality of remuneration between hospital and GP training posts is urgently needed
- Better co-ordination between stakeholders is imperative
- Trainer support needs to be embedded in the system, e.g. in other countries trainers get paid an allowance for training which they can add to their income to ensure this role is taken seriously.

Examples:

DK

In Denmark there is a gate-keeping system with GP's as central coordinating persons in our health care system – there is general agreement amongst stakeholders that it also should be like this in the future. This position gives the GP's a position of very

important persons in the healthcare system. The income for GP's are equal to other specialists.

The Danish health care system is financed by a national health insurance system – it is tax paid.

NL

Same as in Denmark, except for the income (generally 1/3 lower than hospital specialists; still a good income, around 4 times a standard Dutch income)

UK

The UK used to have a strict gate keeping system via GPs. Recent reforms to allow more flexibility of access means that the number of entry points is diversifying e.g. walk –in centres, centres in stations, etc. However patients may not access consultants, even privately without the consent of their GP (and expect re-imbursement). The UK is free at the point of need and independent of the ability to pay, and is funded by the government .There are 35,000 GPs who see 140 patients per week (if full time).

International comparisons (for 2000, per capita total health spend):

- $1,813 UK,$2,387 France,$2,580 Canada
- Drs/1000 : UK 2,France 3.3, US 2.8

In the UK the Government decided to increase NHS spend by 7.4% per annum for 5years; from 6.8% GDP (1997), to 9.4% GDP (2007/8) top end of EU. This was to increase the supply of health care professionals (55% increase medical students), modernise infrastructure (IT, PFI building). It also set National standards & targets: moves to address the postcode lottery, NICE, NSF, targets, inspection & regulation (re-licensing), published performance indicators, direct intervention if needed.

4. The trainer.

In attendance: Dr Vittoria Braun, Berlin.

GP at Kopenik and Member of the Board of the Landesärtze Kammer for the last 8 years, Dr Braun is also on the Committee of the Bundesärtze Kammer.

Dr Braun kindly hosted us at The Charité in Berlin and we would like to express our thanks to her for her warmth and kindness.

Dr Braun originally trained in East Germany and she mentioned that there had been a different system in East Germany with a dedicated vocational training system and doctors were salaried. This led to 30% of professionally trained doctors being Allgemeinmedezin/generalists and she felt that the status of GPs under this system was favourable.

She runs a vocational training rotation in Kopenik, located on the outskirts of Berlin, and a package of training is in the process of being implemented. There is a day release twice a month. Despite the fact that there is a separate Weiterbildungsordnung for general practice they have locally managed to form a rotation where general medical/ general surgery/orthopaedic/paediatric trainees come out into the practice. It is traditional in Berlin to have access to these specialities and training them together in this way emphasises that there is no competition e.g. between GP trainees and specialists.

There are 150 training practices in Berlin. You need at least 6-800 patients to be able to train a young doctor and ensure adequate exposure to diverse case-mix. It is based on the apprenticeship model and learning by doing.

Dr Braun reflected that there had been better respect under Communism for Allgemeinemedizin/ GPs. In contemporary Germany GPs need to be recognised and respected as specialists too, and there must be no divide between generalists and specialists. Currently there is a state of flux. By 2020 there will be 15,000 GPs short.

The solution as seen by Dr Braun was that more power is needed for GPs to “sell” it to newly qualified doctors. There needs to be more GPs on the Committee of the Bundesarzte Kammer to give more voice to GP issues, and to impact directly on the Kammer from their first day as GPs. Dr Braun felt that there was a need for the re-emancipation of GPs.

University Dept of General Practice

Dr Braun is the lead here and she has 19 people in the department under her and recently she has lost 2 of her staff: one to the Netherlands, one to work in a drug company. She started in 1998 and has built up the department, currently there are 15 colleagues, and 4 full time colleagues. She finds the tension between running a practice and academic work significant: there are 2000 patients in her practice so she must go and attend to them. Universities on the other hand find it difficult to think about teaching and also care, and then care in the community. In terms of being a University

department the governing body is interested in publications and impact factors. Managing the interface and diverse expectations is difficult in such circumstances. In Rostock the KV have funded a post there which is probably a better model. Dr Braun feels that "We (GPs) play in the university with no tools"

Development model

There needs to be a united front of GPs all over Germany. The Landes Ärztekammer is a good institution with a heritage and so this one alone needs to represent GPs and to co-operate with others. Berlin sets a good example of this approach which is historically based. There was a tradition of more-co-operative thinking in the DDR. The workforce was tightly regulated according to needs and there was no excess of doctors and so it was much easier to foster a collaborative and co-operative environment. Now in contemporary Germany there is a proliferation of doctors and each naturally fights for a place. Therefore there needs therefore to be workforce regulation according to Dr Braun as in 3-5 years there will be too few doctors to buy their practices also in the east of the country (as there are now in the west).

Co-operation occurs when money is the issue: use this as a driver. Dr Braun suggests that there should be a Hausärzte Kammer which should lead on such changes as she sees as being supportive of the future of general practice. The German College DEGAM (Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin) is perceived as an academic not political body, and so she feels it lacks the political clout needed to move matters.

Dr Braun described the training that occurs in her own practice. For 18 months she works with an assistant. For a new trainee GP during the first week there is close supervision and in the first month they work in parallel rooms and then exchange and show each other patients. She has literature in her practice and hold regular teaching sessions with her trainee weekly, once a month they go out socially. It is a classic apprenticeship model. The Berlin group of trainers also asked the trainees to evaluate them. 3-4 GPs received a poor evaluation, they were given feedback and if they continued to receive a poor evaluation by future trainees then they were removed from the training pool.

Summary

Dr Braun was clearly an exceptional GP with singular vision and experience. She provided an interesting contrast as she has developed her career under 2 different systems. Respect for general practice and workforce management are fundamental for her in terms of making progress. She sees the Kammer and its reform as the way forward to stimulate a better and more egalitarian environment which will in turn stimulate entry into General Practice and ameliorate significant gaps which she sees on the horizon. She sees the impetus as coming from a political rather than an academic quarter.

She appears to be a seasoned trainer who has thought through the training at her practice where she develops a close relationship with her trainee on an apprenticeship model. Dr Braun manages the interface between her university department and clinical

commitments, but this is not without conflicting demands and tensions. She feels that the fledgling department which she has worked hard to build up is measured by standards which pertain across the board at universities and are not context sensitive from her perspective.

Commentary and recommendations:

- There is clearly a will and a movement to progress vocational training on an apprenticeship model.
- Structures are in place. However there are obvious tensions and urgent support is needed to rectify looming deficits of GPs.
- Financial pressures seem significant and need to be urgently reviewed and ameliorated as this creates difficulties at all levels from recruitment of trainees trainers academics, retention, training of trainees and trainers, academic work, etc.
- This means that the traditional academic sense of scholarship, teaching, research and academic institutional collegiality are inevitably compromised and this facet also needs to be supported.
- Time (due to many diverse commitments) is tight: it appears difficult to get time to manage the academic/clinical interface optimally
- Professionalism needs to be fostered –trainees have little time to come and see an interesting patient.
- There is an urgent need to recognise the role of trainers and provide support and training for them.
- Assessment seems relatively un-developed and appears to need reform.

Examples

NL DK UK-see above commentary

Dissemination

DEGAM
Participants
SVR an independent think tank at Department of Health
Bundesarztekammer
Administrators
Insurance funds
GPs, especially trainers

Biographies

Dr Teresa Pawlikowska

Dr Pawlikowska is Associate Clinical Professor at Warwick Medical School where her special interest is in GP input into both undergraduate and postgraduate training.

In her previous post as Head of the International Unit in the department of general practice at University College London she was responsible for the roll-out of general practice in former Eastern Europe under several EU Phare and World Bank programmes and input into countries as diverse as Albania and Japan. This included curriculum development and support, establishing, supporting and mentoring new university departments of general practice and service development (promoting model practices and primary care teams).

She also devised and taught on conversion courses and "train the trainers" courses. Her special interest is in communication and consultation skills teaching and research. She has over fifteen years experience of the development of educational training programmes at both under graduate and post graduate levels.

She is a member of the Academy of Medical Educators in the UK and chairs the Education Committee at The European General Practice Research Network (EGPRN) as well as being an elected Board Member.

After many years as a GP principal in her central London group practice, she works as a sessional GP in Warwickshire.

Luc van Berkestijn, MD, PhD

Dr van Berkestijn was general practitioner from 1974-1984, GP-teacher/tutor at Utrecht University from 1984-1994. He did his thesis on Quality Assessment in Family Practice (1996). From 1996-2007 he served as Deputy Head of Department of the GP-vocational training at Utrecht University. He was author of "The Outline of the GP-Curriculum" for The Netherlands, of "The Final attainment levels for GP Vocational Training" (2000), and of "The Competency Profile of the General Practitioner" (2005).

He worked for five years as chairman of the Taskforce on The Modernization of GP-Vocational Training in The Netherlands (2001-2006), carried out by representatives of all eight University Departments for General Practice in The Netherlands.

Dr. Roar Maagaard,

GP and Ass. Clinical Professor, University of Aarhus, Denmark.
Graduated 1982 from Univ. of Aarhus, Specialist in GP/FM and working as GP since 1988. Partner in an 8 doctor practice near Aarhus. Working as a GP trainer since 1990 and since 1991 Regional Coordinator of GP-training in County of Aarhus (now Region Midtjylland).

1998-2005: Chairman of educational committee in the Danish College of GP's (DSAM) – and in this period responsible for creating and implementing a new 5 year training scheme for specialist education in GP in Denmark.

Since 2005: President of Danish College of GP's (DSAM).

Regional GP-training coordinator since 1990 in the County of Aarhus – and later in Region Midtjylland. From 2002 Associate professor University of Aarhus/Region Midtjylland with responsibilities for Postgraduate GP training.

Since 2002 Danish Member of EURACT Council (European Academy of Teachers in General Practice) and since 2005 elected as Honorary Secretary and Vice-president of EURACT.

Since 1995: Member of the committee for education and research in the Danish Medical Association.

APPENDICES

These present further information from participants and interviewees and one further interview with written responses from a representative of the German Medical Association

Time Table

Wednesday 4 February 2009	
14.00	Welcome Updating schedule Definition of topics and relevant questions Introduction German Health Care System
15.30	Federal Chamber of Physicians (Bundesärztekammer) Dr. Cornelia Goesmann (Vice President)
17.30	General discussion
Thursday 5 February 2009	
9.00	Drs. Haffner/Schmidt/Dicke/ Pruskil/Schumann (Trainees / registrars)
11.00	Dr. Stefanie Joos
14.00	BMG (Dr. Heinz Haage – off sick, N.N.)
16.00	DEGAM (Prof. Thomas Lichte, Dr. Marcus Schmidt), Herr Heil
Friday 6 February 2009	
9.00	GKV (Dr. Christian Peters, Simone Burmann, AOK BV)
11.00	Prof. Vittoria Braun (Charite, Berlin Physician Chamber),

1. Trainees PowerPoint
2. General Practice training networks first steps of the Competence Centre General Practice Baden-Wurttemberg
3. General practice in Berlin Vittoria Braun
4. Educational reform 2000-2005 Luc van Berkestijn

References:

Structure and gate keeping:

Starfield, B. (1992). Primary care: concept, evaluation and policy. New York, Oxford University Press.

Haggerty, J., R. Reid, et al. (2003). "Continuity of care: a multidisciplinary review." BMJ **327**: 1219-1221.

The UK situation (see Department of health website also)

Comparison of Primary care trusts:
http://www.info.doh.gov.uk/nhsfactsheets.nsf/vwHelp/Primary%20care%20trusts?OpenDocument

Payment of GP contract Quality and outcomes framework QoF an example:
http://www.dhsspsni.gov.uk/qof_context

Comparisons:

Boerma, W. (2003). Profiles of general practice in Europe. An international study of variation in the tasks of general practitioners. Utrecht, Netherlands Institute for Health Services Research (NIVEL).

An international comparison
http://www.biomedcentral.com/content/supplementary/1472-6963-9-26-s1.doc

The essence of primary care:

McWhinney, I. (1998). "Primary care: Core values. Core values in a changing world." BMJ **316**(1807-1809).

Part of a series of articles on BMJ website, and consolidated as Pringle, M. (1998). Core Values in Primary Care, BMJ Books.

Vocational Training

An overview http://www.gpvts.info/- an accessible specific example

The Condensed Curriculum Guide
Author: Riley
ISBN: 9780850843163
Pages: 300
Publisher: RCGP
Published: September 2007

General Practice Specialty Training: Making it Happen
Author: Mohanna
ISBN: 9780850843170
Pages: 200

Publisher: RCGP
Published: March 2008

Management for New GPs
Author: Wilkie
ISBN: 9780850843194
Pages: 230
Publisher: RCGP
Published: Jan 2009

OP85 - A Toolkit for Trainer Appraisal and Development
Author: Rutt
ISBN: 9780850842869
Pages: 41
Publisher: RCGP
Published: 2003

Talking about my patient: the Balint approach in GP education.
Ruth Pinder, Anne McKee, Paul Sackin, John Salinsky, Oliver Samuel, and Heather Suckling
Occas Pap R Coll Gen Pract. 2006 April; (87): 1–32.
PMCID: PMC2560909

Balint Groups are considered essential for training Gps
http://www.balint.co.uk/about_us/balint_groups.html

Communication

De Haes, H. (2004). "Communication in general practice: the Second Dutch National Study." Patient Educ Counsel **55**: 1-2.

Van der Brink-Muinen, A., P. Verhaak, et al. (1999). The Eurocommunication Study. An international comparative study in six European countries on doctor-patient communication in general practice. Utrecht, Netherlands Institute for Health Services Research (NIVEL).

Note from TP: There is of course a huge literature on communication, medical communication and GP communication and consultation, this is but a taster. As it is an interest I am happy to support or provide detail as needed.