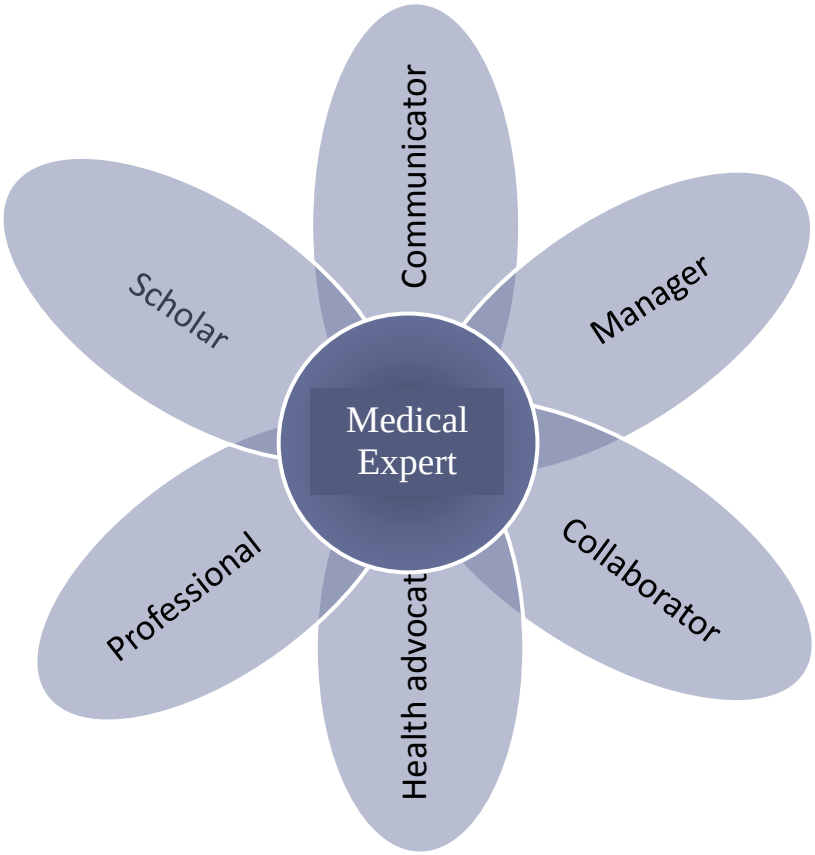
Competence-Based Curriculum

General Practice

January 2019



Acknowledgement

We would like to thank the participants who helped to develop this competence-based curriculum for general practice between 2010 and 2015.

This acknowledgement is particularly due (in alphabetical order):

Georg Barth, Iris Boehmer, Jessica Bungartz, Paola Brusa Düwel, Jean-Francois Chenot, Norbert Donner-Banzhoff, Günther Egidi, Christiane Eicher, Peter Engeser, Johanna Eras, Elisabeth Flum, Susanne Grundke, Nicolette Holtz, Bert Huenges, Jürgen in der Schmitten, Cornelia Jäger, Kristina Jäkel, Stefanie Joos, Andreas Klement, Michael Klock, Thomas Kühlein, Thomas Ledig, Thomas lichte, Roar Maagaard, Thomas Maibaum, Katharina Mendler, Frank Peters-Klimm, Marco Roos, Guido Schmiemann, Odilo Schnabel, Ute Schnell, Frank Schröder, Sven Schulz, Simon Schwill, Johannes Spanke, Jost Steinhäuser, Katja Stengler, Joachim Szecsenyi, Iri Veit, Armin Wiesemann

The English version was translated by Jean-Francois Chenot, Gabriele Gremer, Marco

Roos and Jost Steinhäuser

Lübeck, January 2019

Contact person:

Prof. Dr. med. Jost Steinhäuser

Institute for Family Medicine

University Hospital Schleswig-

Holstein Campus Lübeck

Germany

E-mail: jost.steinhaeuser@uksh.de

Table of contents

Part III: Procedures

III.1 Physical examination

III.2 Diagnostics

III.3 Therapy

Feedback sheet further training discussion

Definition of general practice

General practice includes the basic care of patients of all ages with physical and mental health disorders in emergency, acute and long-term care as well as health promotion, health education, prevention and rehabilitation.

General practitioners are specialized in being the first physician to contact with all kinds of health problems.

The method of general practice is based on a holistic case understanding. It takes into account the patient's disease concept as well as the somatic, psychosocial, socio-cultural, and health economic aspects. It includes a family doctor function, in particular the care of the patient in the context of his family and social community, as well as in the domestic environment.

The decision-making process takes into account the epidemiological peculiarities that result, among other things, from the unselected patient population or multimorbidity. These include, for example, step-by-step diagnostics and individual assessment of the benefits and risks of diagnostics and therapy.

The working principles of general practice are a doctor-patient relationship based on continuity and the anamnesis experienced. This includes the consolidation of all medically important data and cross-sector care coordination and integration.

The aim of general practice is to provide high-quality care, which includes the protection of the patient, but also of society from misuse, underuse or overuse.

(see also: https://www.degam.de/files/Inhalte/Degam-Inhalte/Ueber_uns/Positionspapiere/DEGAM-Position_Paper_on_the_Future.pdf)

About this curriculum

This curriculum is intended to familiarize the physician in postgraduate training (AiW) and his or her trainer as a guiding thread and help them to focus on their core competencies at an early stage for later general practice.

The aim is to create a basis and identify essential subject areas that every family doctor should master. The representation of all contents conceivable for general medicine exceeds the framework and thus the manageability of the curriculum. The curriculum should not be confused with a textbook or further training regulations.

In general practice, competences are acquired on a case-by-case basis. Personal development is to take place with the present curriculum to be achieved through continuous, longitudinal self-reflection and feedback between AiW and supervisor

In most cases, the work of the general practitioner begins with the "reason for encounter", the description and interpretation of a symptom or question by the patient, which arises from his or her environment, knowledge and experience.

The general practitioner's working method is therefore often aimed at eliminating dangerous processes, so-called "red flags" in a timely manner in order to wait attentively afterwards ("watchful waiting/test of time"). For general practitioners, it is therefore not always a matter of making diagnoses, but of excluding them. At the same time, general practitioners are confronted with reliable diagnoses and must therefore know the course and therapy of specific clinical pictures.

A general practitioner specializes in being the first point of contact for all consultation occasions. Therefore, all points named as "reason for encounter" should be discussed primarily with a general practitioner. Against this background, the learning contents in Part I of this curriculum are presented in two different ways: consultation-related and diagnosis-related.

Here, frequent "reasons for encounter" and "diseases/diagnoses" in general practice care (according to ICD 10, ICPC2 and the experiences of the physicians involved in this project) are listed.

In addition to medical expertise, general practitioners need a number of other skills in their daily work. These competences have to be developed and promoted in further education. They are shown in Part II of this curriculum. The competence model applied here is based on the Canadian CanMeds competences and has been culturally adapted for use in Germany (http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e).

Part III lists exemplary procedures that are frequently carried out in general practice or are relevant for safety reasons.

How to use the Curriculum

1: Self-reflection

Each AiW assesses its own level of development in theory and practice for each topic of Parts I-III. The following applies:

"I feel routined and safe in a subject."

"I still feel insecure in a topic and would like to continue to develop myself in this area."

If a topic area is ticked off, a feedback discussion with the trainer should be sought. The comment fields on the page can be used to prepare the feedback discussions.

2: Feedback

During the interview, the AiW has the opportunity. ..

- to get an assessment of his or her current state of development from the trainer

- to compare his or her self-assessment with the external assessment

- to set further training targets for the next defined period of time or training section.

The form at the end of the document can be used as a guideline and documentation (feedback form).

Referral

- repetition of the described procedure at regular intervals in order to go through an individual "learning spiral

- concrete review by the AiW of the "tailor-made training objectives" in order to guide and ensure the targeted development of its competencies within the training period.

Part I: Medical Expert

In line with the working reality of a general practitioner, the medical expertise is listed according to reasons for encounter and diseases/diagnoses below. For better orientation, the classification is mainly according to organ systems. Some reasons for consultation (e.g. shortness of breath, dizziness) may be assigned to different organ systems/causes. In order to avoid redundancies, these advisory events are each listed under one chapter only.

Reasons for encounter

A reason for encounter can conceal a multitude of diagnoses, always taking into account the psychological, social and somatic dimensions.

A reason for encounter triggers a complex subsequent procedure (treatment episode). The treatment episode can, for example, include subsequent preventive, diagnostic, therapeutic or coordinating measures. In principle, within the framework of a treatment episode always will be decided:

1. Are there indications of an acutely threatening disease ("red flag") which requires immediate action and which differential diagnoses may be considered?

2. Which procedure (subsequent diagnosis and therapy) should be initiated (or deliberately not initiated)? This includes diagnostic and therapeutic options, which are provided by general practitioners, or the referral/hospital admission and interpretation of the findings returned afterwards.

Diseases / Diagnoses

The following categories are distinguished in the subject area Diseases:

Diagnostics and therapy and, if given, prevention and long-term care.

The assessment for all categories generally always includes critical weighing and, if necessary, the justified waiver of possible measures.

Explanation of terms

Prevention

Goal: That the AiW knows important measures, can carry them out and, if necessary, initiate them, which serve this purpose...

a) to prevent or slow down the development of a disease (primary prevention, e.g. vaccinations).
b) to prevent a worsening, recurrence or chronification of an existing but asymptomatic disease (secondary prevention, e.g. early detection examinations).
c) to favourably influence the progression of a symptomatic disease, prevent complications and mitigate the impact of the disease (tertiary prevention, e.g. rehabilitation).
d) To contain overuse and at the same time to avoid underuse and misuse (quaternary prevention).

Diagnostics

Goal: That the AiW ...

a) knows, can carry out and evaluate diagnostic measures that are possible in the general practitioner's practice (the ability to critically review the test quality should also be mastered here).
b) knows and, if necessary, can initiate further diagnostic measures that can be carried out outside the general practitioner's practice.
c) knows the respective differential diagnoses.
d) can deal with the feelings of a patient with regard to his illness.

Therapy

Goal: That the AiW ...

a) knows therapeutic measures that are possible in general practice and perform them.
b) if necessary, knows further therapy options outside the general practice and can initiate them.

Long-term care

Goal: That the AiW...

is able to establish a sustainable doctor-patient relationship. To achieve this, he must know and be able to carry out important measures and forms of communication that are necessary for the long-term care of his patients. This includes, for example, joint decision-making with the patient, psychosocial support, disease management programmes, laboratory controls, imaging controls, cooperation with other specialists, follow-up controls and knowledge of the specifics of guiding chronically ill people.

I.1 Metabolism, nutrition and digestive system

Reasons for encounter

	"red flags"/ Differential Diagnoses	Procedure	Comments
Nausea/vomiting			
Swallowing disorders			
Changes of appetite / thirst			
Weight changes			
Changes in bowel movement / digestion			
Abdominal pain			

Diseases and diagnoses

	Diagnostics Therapy	Prevention Long-term care	Comments
Gastritis/Ulcus			
Reflux disease/oesophagitis			
Gastroenteritis			
Appendicitis			
Diverticulose/-itis			
Cholelithiasis and Cholecystitis			
Pancreatitis			
Hepatitis			
Chronic inflammatory Bowel diseases			
Hernias			
Anemia			

Gastrointestinal bleeding			
Malignancies of the gastrointestinal tract			
Haemorrhoids			
Anal venous thrombosis			
Diabetes mellitus			
Thyroid dysfunctions and pathologies			
Fat metabolismdisorder (hypercholesterolemia)			
Hyperuricemia (gout)			
Food intolerance			
Obesity			
Malnutrition			
Irritable bowel syndrome			

I.2 Area of respiratory organs and ears

Reasons for encounter

	"red flags" Differential Diagnoses	Procedure	Comments
Snuffles / Sneezing / Stuffy nose			
Hoarseness / sore throat			
Cough/pruductive cough			
Shortness of breath / dyspnoe			
Nosebleeds			
Hear loss			

Diseases and Diagnoses

	Diagnostics Therapy	Prevention Long-term care	Comments

Allergic Rhinitis			
Rhinosinusitis			
Upper respiratory tract infection			
Pneumonia			
COPD			
Bronchial asthma			
Obstructive sleep apnea syndrome			
Bronchial carcinoma			
Otitis media			
Otitis externa			
Tinnitus			

I.3 Area of the cardiovascular system

Reasons for encounter

	"red flags" Differential Diagnoses	Procedure	Comments
Palpitations			
Chest pain			
Leg swelling			
Heartophobia			

Diseases and Diagnoses

	Diagnostics Therapy	Prevention Long-term care	Comments
Arterial hypertension			
Coronary heart disease			
Heart failure			
Auricular fibrillation			

Other cardiac arrhythmias			
Diseases of the heart valves			
Peripheral arterial occlusive disease			
Chronic venous insufficiency/varicosis			
Thrombosis			
Lymphedema			

I.4 Area of the musculoskeletal system / pain / injuries

Reasons for encounter

	"red flags" Differential Diagnoses	Procedure	Comments
Acute pain			
Head			
Ear			
Cervical spine			
Joints			
Arms			
Thorax			
Abdomen			
Back			
Legs			
Wounds			
Fractures			
Distortion			
Chronic pain			
Head			
Cervical spine			

Joints			
Arms			
Thorax			
Abdomen			
Back			
Legs			
Wounds			
Other			
Paralysis/weakness			
Tremors			
Joint swelling			
Posture problems			

Diseases and Diagnoses

	Diagnostics Therapy	Prevention Long-term care	Comments
Arthrosis			
Osteoporosis			
Rheumatic diseases			
Herniated disc			
Degenerative spinal illnesses			
Foot deformities			

I.5 Eye and nervous system area

Reasons for encounter

	"red flags" Differential Diagnoses	Procedure	Comments
Red eyes			
Visual disturbances			
Disturbances of equilibrium/ dizziness			
Sensory disturbances (eg.sensitivity disorder)			

Diseases and Diagnoses

	Diagnostics Therapy	Prevention Long-term care	Comments
Glaucoma			
Cataract			
Conjunctivitis			
Migraine			
Tension headache			
Apoplexy			
Dementia			
Parkinson's disease			
Delir			
Multiple Sclerosis			
Epilepsy			
Polyneuropathy			

I.6 Family planning, reproductive organs and urinary tracts

Reasons for encounter

	"red flags" Differential Diagnoses	Procedure	Comments
Questions about sexual health			
Impotence			
Contraception			
Desire to have children			
Pregnancy			
Breastfeeding			
Vaginal discharge			
Changes in urinary excretion			
Dysmenorrhoea			
Experience of violence			

Diseases and Diagnoses

	Diagnostics Therapy	Prevention Long-term care	Comments
Urinary tract infection			
Genital mycoses			
Urolithiasis			
Urinary incontinence			
Climactericc symptoms			
Breast carcinoma			
Prostatic hyperplasia			
Prostate carcinoma			
Acute renal insufficiency			
Chronic renal insufficiency			

I.7 Skin area

Reasons for encounter

	"red flags" Differential Diagnoses	Procedure	Comments
Itching			
skin change			
Sweating			
Hair loss			
Nail change			

Diseases and Diagnoses

	Diagnostics Therapy	Prevention Long-term care	Comments
Bacterial skin infections			
Lyme disease			
Viral exanthema			
mycoses			
Allergies			
Drug exanthem			
Atopic Eczema			
Psoriasis			
Skin tumours			
Abscess			
Chronic wounds			
Ingrown nail			

I.8 Area Changes of consciousness, thinking and feeling / Psychosocial counselling events

Reasons for encounter

	"red flags" Differential Diagnoses	Procedure	Comments
Syncope			
Memory -/ concentration disorders			
Insomnia			
Mood swings			
Weakness/ exhaustion/ tiredness			
Overload and overstrain			
Acute life crisis			
Addiction			

Diseases and Diagnoses

	Diagnostics Therapy	Prevention Long-term care	Comments
Depression			
Somatoform disorders			
Eating disorders			
Anxiety disorders			
Posttraumatic stress disorder			
Psychoses			
Tobacco addiction			
Alcohol abuse and addiction			
Drug dependency			
Drug addiction			

I.9 Special features of children and adolescents

Reasons for encounter

	"red flags" Differential Diagnoses	Procedure	Comments
Fever			
Cough			
Sore throat			
Earaches			
Stomach pains			
Diarrhoea			
Vomiting			
Failure to thrive			
Developmental disorders / behavioural abnormalities			
Exanthema			
Itching			
Vacciantion			
Special features of child traumatology			

I.10 Care of chronically ill and elderly patients

Reasons for encounter

	"red flags" Differential Diagnoses	Procedure	Comments
Multimorbidity			
Polypharmacy			
Need for care			
Restlessness			

I.11 Palliative care sector

Consulting occasions

	"red flags" Differential Diagnoses	Procedure	Comments
Terminal care			
Support for grief work			
Support for relatives			
Symptom control			

Emergencies

	diagnostic	Doctors (Initial) Therapy	Comments
.. .from the area of the cardiovascular system			
Hypertensive crisis			
Brady- or tachycardic arrhythmias			
Acute coronary syndrome			
Acute arterial occlusion			
.. .from the area of the abdomen			
Acute abdomen			
Gastrointestinal bleeding			
... from the area of the respiratory organs			
Pulmonary embolism			
Asthma attack			
(Tension-) Pneumothorax			
Pulmonary edema			
Exacerbated COPD			
Anaphylaxis			

.. .from the area of the nervous system and the psyche			
Status epilepticus			
Apoplectic Insult			
Suicide			
Psychoses and aggressive behaviors			
Delir			
Panic attack			
.. .from the area of the eyes			
Chemical burn			
Foreign bodies in the eye			
Glaucoma attack			
... after trauma			
Injuries, stab or, gun wounds, bites, cracks, squeezing wound			
Burn injuries			
Electrical accidents			
... Other			
Birth/Abort			
Poisonings			
Skull - Brain Trauma			
Hypo-/Hyperglycaemia			

Part II: Competences according to the CanMEDs Roles

II.1 Communication

Communicational skills are essential in order to ensure trustworthy and sustainable relationships, to maintain them, conduct comprehensive anamnesis, formulate diagnoses, communicate information appropriately, and facilitate a shared treatment approach.

General practitioners understand patients' concepts of disease, their values, feelings and expectations, and the impact of disease on the lives of patients and their families. They use the repeated encounters with patients to expand doctor-patient relationships and promote the healing effect through care and interaction.

General practitioners have the ability to provide information adapted to the situation.

Core competencies

II.1.1 Establishing and maintaining relationships with patients and family members

I am able/able to control...

	comments
a) to listen actively and empathetically and to a conversation, to questions and to to encourage an exchange.	
b) basic communication techniques such as active listening, verbalizing, etc. of emotions and responsiveness to non-verbal clues	
c) to respect the self-determination, life arrangement and social origin of the patients (orientation towards the living environment and social space) and their values.	
d) promote the participation of the patient in medical decisions (e.g. shared decision-making).	
e) Skills for culturally sensitive communication.	

II.1.2 Collection, consolidation and documentation of information

I am able/able to control....

	Comments
(a) to actively identify relevant somatic, psychological and social aspects in the context of the anamnestic survey	
b) to consciously use communication techniques	

in the collection of anamnesis.	
c) to keep clear and comprehensible documentation about doctor-patient contacts and treatment plans	

II.1.3 Transmission of information to patients and, where appropriate, family members

I am able/ able to control

	Comments
a) to inform patients and family members empathetically and in a situation-adapted manner	
b) to convey information in such a way that it is understood, that it encourages discussion and participation in the decision-making process	
(c) Skills in communicating information in difficult medical and human situations (e.g. life-threatening illness, addiction, etc.)	
d) proactively address errors or critical events	
e) the tension between medical confidentiality and information transmission	

II.1.4 Development and maintenance of cooperation with persons from the working environment

I am able/ able to control

	Comments
a) to effectively use written or oral communication in the joint care of a patient, e.g. referral and admission	
b) to consider the protection of trustworthy patient data when exchanging patient-related data	
c) to communicate effectively as a member or leader of a treatment team or other professional group	
(d) deal with conflicts	

II.1.5 Communication as therapeutic intervention

I am able/ able to control

	comments
a) to use information collected in the patient's environment (e.g. anamnesis) therapeutically	
b) to enable therapeutic interventions by means of basic counselling techniques	
c) to proactively search for possible health-promoting factors in the patient ("salutogenic approach")	
d) to use the "family system" for therapeutic intervention	

II.2 Cooperation

The general practice is the central place of care for the majority of patients. General practitioners are often the first point of contact in the health care system and play a central role in cooperation with other health professionals and other institutions in order to provide optimal medical care for their patients. These parties involved in care are referred to in the following as "network partners".

Depending on individual care needs, patients are dependent on the cooperation of the treating general practitioner with other network partners.

The general practitioner's task is to coordinate and integrate in order to ensure optimum care and support.

Core competencies

II.2.1 Teamwork: cooperation, communication and coordination with medical and non-medical network partners in the care of patients

I am able/ able to control

	Comments
a) to clearly formulate my own tasks, responsibilities and limits vis-à-vis to other network partners and to know those of the network partners in relation to the role of general practitioners	
b) to observe the principles of teamwork (e.g. confidentiality, professionalism and mutual respect) and to use the principles of team dynamics to improve the efficiency of a team	
c) to cooperate with others in the design, planning and evaluation of non-clinical tasks (e.g. research, education, training, public health education and administrative issues)	

II.2.2 Maintaining a constructive working atmosphere

I am able/ able to control

	Comments
a) to establish a constructive and relieving error culture.	
b) to cultivate a respectful approach in joint work and to perceive threatening conflicts in cooperation as well as to offer solution strategies (e.g. conflict management)	

II.2.3 Joint decision making: Involvement of patients and

I am able/ able to control

	Comments
to identify treatment goals with patients or patient groups as part of a partnership-based decision-making process and to develop ways of improving health	

II.3 Management

General practitioners coordinate patient care, organise the medical and business interests of the practice and make decisions on the use of limited solidarity funds, taking into account benefits and economic efficiency. General practitioners cope with these everyday medical and business requirements of their practice (possibly by delegation) and balance them with their private lives.

Core competencies

II.3.1 Coordination of patient care in cooperation with other medical institutions, health professionals and social institutions

I am able/ able to control

	Comments
(a) to describe the role of general practitioners in the health system	
(b) to describe and make appropriate use of the logistical and medical capabilities of other medical, health-care and social facilities.	
(c) to cooperate with other medical, health-care and social institutions to provide coordinated patient care.	

II.3.2 Organisation of the medical and business management aspects of practice

I am able/ able to control

	Comments
(a) to set priorities and to give me the time to balance patient care, practice requirements, external activities and private life	
(b) to conduct the business of a practice, including billing and finance	
(c) to guide and manage the human resources in a practice and the collaboration of the practice team	
(d) to establish procedures to ensure continuous quality improvement within a practice	
(e) to use information technology to adequately plan patient care	
(f) the necessary business knowledge, e.g. to draw up and maintain a business plan	
(g) to lead a practice team	

II.3.3 Appropriate allocation of limited resources in health care

I am able/ able to control

	Comments
(a)to recognise the importance of an appropriate allocation of resources in health care	
(b) to apply scientifically proven procedures and management processes for cost-effective care	

II.4 Representation of the patient: Care management and health promotion

General practitioners direct care with the aim of protecting the individual patient and society from overuse, underuse and misuse. General practitioners support their patients by promoting their health and providing them with necessary care and make health resources available in a timely manner (coordination function). This also includes protecting the patient from unnecessary medical measures (quaternary prevention). They are committed to optimising the existing framework conditions.

Core competencies

II.4.1 Addressing Individual Patient Needs

I am able/ able to control

	Comments
(a) to act as the first person to contact and, for long periods, as the sole practitioner for patients in all health matters	
(b) to prioritise the health needs of the patient together with the patient	
(c) to accompany patients of all ages through all aspects of social medicine (including forms such as certificates of incapacity to work, applications for follow-up treatment, rehabilitation, degree of disability, pension entitlement, etc.).	
(d) to advise on the subject of living wills	

II.4.2 Individual health promotion

I am able/ able to control

	Comments
to identify and promote individual resources for health promotion and disease prevention.	

II.4.3 Promotion of public health

I am able/ able to control

	Comments
(a) to identify meaningful changes at the community level to improve public health and, where appropriate, to stimulate services	
(b) the basics of social medicine	
(c) To raise awareness of the potential role conflict that may arise as a patient advocate, practice manager, patient safety advocate and pilot against a backdrop of limited resources	

II.5 Learning and teaching

As reflective learners, general practitioners keep themselves up to date with the current state of knowledge throughout their lives and, as lecturers, pass on this knowledge to students, doctors in continuing education, medical doctors and other medical professionals/Specialists etc. more. In the context of patient care and health education, they pass the knowledge on to patients, their relatives and the public.

Core Competencies

II.5.1 Individual Foundations of Learning and Teaching

I am able/ able to control

	Comments
(a) to continuous, self-determined learning on the basis of an individual-oriented and at the same time evidence-based medicine	
(b) to recognize and close gaps in one's own knowledge and skills	

II.5.2 Health education of patients, their relatives and other health professions as well as the general public

I am able/ able to control

	Comments
to adapt the way I convey information to the respective target group	

II.5.3 Critical evaluation of information, its sources and its relevance to its practice

I am able/ able to control

	Comments
(a) to formulate a question, to identify suitable sources of knowledge, to evaluate the quality and goodness of information, to interpret relevant statements from the identified evidence, to evaluate them critically and to check their applicability	
(b) draw conclusions from critical source studies and incorporate them into clinical care	

II.5.4 Generation, dissemination and application of new scientific findings in practice

I am able to/ able to control

	Comments
to present information on medical topics to the public	

II.6 Professionalism

General practitioners are committed to promoting the well-being of individuals and the population in accordance with ethical principles, personal integrity and appropriate social conduct. These commitments form the basis of the social contract between physician and society.

Core competencies

II.6.1 Fulfilment of obligations towards patients, profession and society

I am able/ able to control

	Comments
(a) to practice professional medical conduct through honesty, authenticity, integrity, reliability, compassion, respect, social conduct and commitment to the well-being of the patient and the population.	
(b) Comply with the obligation to provide quality care and maintain competence.	
(c) Identify and respond appropriately to ethical issues that arise in practice.	
(d) Treat colleagues and employees with respect and resolve conflicts of interest in an appropriate manner.	
(e) To consider professionally and legally defined principles and limits for patient confidentiality (duty of confidentiality).	
(f) Directly and respectfully alert colleagues if their conduct could endanger patients or others.	
(g) To name the structures of medical self-administration and to be able to explain their functions.	

II.6.2 Compliance with the principles of medical ethics (medical professional code of conduct)

I am able/ able to control

	Comments
(a) to comply with the professional, legal and ethical codes of medical practice as well as relevant laws (e.g. basic principles of health insurance medical care)	
(b) to comply with the rules and legal obligations governing the operation of a practice	
(c) to be accountable to medical committees	
(d) to recognize and react appropriately to the unmedical behaviour of others as well as one's own in the practice	
(e) to get involved in the work of medical committees	

II.6.3 Self-protection (burnout prophylaxis) and sustainable practice

I am able/ able to control

	Comments
(a) to balance personal and professional needs in order to ensure my personal health and sustainable practice	
(b) with the aim of establishing a balanced work-life relation	
(c) to recognize the needs of other health care professionals and to promote their sustainable self-protection.	

I.6.4 Self-reflective action

I am able/ able to control

	Comments
(a) to recognize my own (professional) limits, to keep them and, if necessary, to seek help for further development.	

(b) to reflect on my actions and to understand how attitudes and feelings influence my field of work.	

Part III: Procedures*

*CAVE: The procedures mentioned here do not refer to the performance records required in the different continuing education regulations ("logbooks") of the respective federal states!

III.1 Physical examination

	Comments
Internal organs	
Nervous system	
ENT (e.g. otoscopy)	
Eye (e.g. ectropioning, visual acuity control, orienting perimetry)	
Musculoskeletal system (e.g. shoulder, spine, knee, hip)	
U1-J1/juvenile occupational health and safety investigations	
Early detection examinations (e.g. skin cancer screening, digital rectal investigation)	
Post-mortem examination	

III.2 Diagnostics

	Comments
(long-term) ECG	
(Long-term) blood pressure measurement	
Pulmonary function testing	

Sonography of the abdomen and retroperitoneum	
Diagnostic punctures (e.g. ascites, knee joint effusion) bladder catheterization	
Presence and emergency laboratory (e.g. U-Stix, test for occult blood in stool)	
Microscopic evaluation of the urine sediment	

III.3 Therapy

	Comments
Emergency treatment (e.g. securing the airways, oxygen therapy, mask ventilation, insertion of a laryngeal tube)	
Securing and restoring the circulation	
Resuscitation, defibrillation	
Verbal intervention techniques	
Prescription (e.g. of physiotherapy, remedies and aids, psychotherapy)	
Social medicine (e.g. rehabilitation application)	
Guidance of nutritional measures	
Complementary medical procedures	
(Compression) bandages	
Cerumen removal	
Infiltration of local anaesthetic	
Infusion therapy	
Treatment of acute wounds (e.g. surgical wound suture, adhesive bonding)	
Treatment of chronic wounds (e.g. wound debridement)	
Minor surgery (e.g. abscess cleavage, relief of a subungual haematoma, drainage of acute paronychia)	
Removal of a foreign body (e.g. conjunctival, ear, nose)	
Tamponing the nasal cavity	
Oberst- Anesthesia of fingers and toes	

Splints of injured extremities	
Transurethral catheter placement	
Peripheral cannula placement	
i.m. injections/vaccinations	
Port puncture, port flushing	

Feedback form*

Date: .....

Name of physician in training: .....

Name of authorised trainer: .....

Number of months of the training period: .....

A. Progress to date (cf. tasks/goals of previous interview):

.....

.....

.....

B. Current topics and contents:

.....

.....

.....

Focal points of the continuing education interview:

.....

C. Tasks/goals until the next continuing education interview:

.....

.....

.....

Next continuing education interview on: .....

*Recommended is at least one continuing education interview per month, ideally supplemented by feedback on video recordings of consultations (including clinical examination) of the physician in continuing education.