



DEGAM-Position Paper on the Future

General Practice — Focused on the Whole Person

Positions on the future of general practice and family medicine

German College of General Practitioners and Family Physicians

List of contents

Preamble	S. 3
Basic position on the future (1-14)	S. 4
Position on education (15-16)	S. 18
Position on specialist training (17-18)	S. 20
Position on continuing education (19)	S. 22
Position on research (20-21)	S. 23
Position on quality promotion (22-24)	S. 26
Imprint	S. 29

First draft:

Heinz-Harald Abholz, Attila Altiner, Ottomar Bahrs, Erika Baum, Martin Beyer, Jean-François Chenot, Norbert Donner-Banzhoff, Günther Egidi, Peter Engeser, Antje Erler, Ferdinand Gerlach, Andreas Klement, Manfred Lohnstein, Armin Mainz, Hans-Michael Mühlenfeld, Wilhelm Niebling, Uwe Popert, Martin Scherer, Anne Simmenroth-Nayda, Guido Schmiemann, Antonius Schneider, Jost Steinhäuser, Armin Wiesemann, Stefan Wilm

With the assistance of:

Nadja Christner, Edmund Fröhlich, Philipp Gehring und Anke Schmid

Graphics:

Bene von Schorlemer

As far as possible, the explanation of each particular position includes the major, selected sources. The authors consciously avoided comprehensive derivations and detailed lists of references in the interests of a succinct and clear presentation.

Preamble

The aim of the following presentation of forward-looking positions is to create a new profile for general practice that has positive connotations and can be concisely communicated to the general public. It must become clear to every citizen of Germany that and why general practice is as demanding as specialized high-tech medicine. The DEGAM positions are also aimed at supporting general practitioners and family doctors, communicating a sense of excitement and helping to look constructively into the future. In so doing, the objective is to provide a positive view that is in contrast to the complaining and bad-mouthing of one's own the profession that is currently so widespread.

The current paper will outline how DEGAM expects the profession of family doctor to develop in the future, what role family practice-based primary care will play in a sustainable health system and what solutions DEGAM recommends for special problems in rural areas. The DEGAM positions do not claim to be comprehensive and nor does the presentation claim to provide a valid picture of the current situation. Some aspects may appear to be provocative when seen in terms of how well they reflect the current situation (e.g. general practice is the core subject in medical studies). It is precisely such points of view that are forward-looking and that aim to present a picture of successful developments that will enable general practice to free itself from the many myths of the past and to become well equipped to face the future challenges of a very quickly changing society.

1. In view of increasing specialization and fragmentation in health care, general practitioners, as generalists, are more important than ever before

Medical generalism describes an approach that looks at patients and their concrete problems. GPs and family doctors are not primarily focused on organs and specific tasks but rather see themselves as specialists for the whole person. They do not claim to be responsible for everything, but rather, in view of the trend towards increasing differentiation and specialization in treatment options, it is the responsibility of the family doctor and GP to provide comprehensive long-term care, e.g. for the chronically ill with multiple diseases and where necessary to coordinate care between various disciplines and professions.

The main task of GPs in the future will remain the provision of primary and basic care. This means GPs will be the first port of call and one where the majority (around 90%) of all consulting issues can be dealt with. This has the further advantage that several consulting issues can be treated simultaneously with only one visit to the doctor. In addition to their main task of providing primary care, GPs and family doctors see themselves as cooperation partners for structured care in which (sub) specialized approaches to the diagnosis and therapy of individual diseases are necessary. In view of shorter hospital stays and an increase in the diseases of old age, multimorbidity and mental (co-) morbidities, the long-term care for a number of illnesses will become more and more important in the future. GPs are the only specialized doctors that have enjoyed broad-based specialist training and, thanks to the way they work, are in a position to provide care for persons as a whole, can regard illness in terms of the patient's background and living situation and can directly use this knowledge to provide "person-centered medicine" in terms of both diagnosis and therapy.

Under the maxim of 'Guiding Patients Through Complexity: Modern Medical Generalism', a high-ranking group of experts from the UK (Independent Commission 2011) named the following core elements:

- Seeing the person as a whole and in the context of their family and wider social environment (particularly important where mental problems are concerned)
- Being accessible and available to deal with undifferentiated illness and the widest range of patients and conditions
- Also in general practice, co-ordinating care across organizations within and between health and social care
- In the context of general practice, taking continuity of responsibility across many disease episodes and over time
- Demonstrating concern not only for the needs of the presenting patient, but also for the wider group of patients or population
- Communicating freely and clearly with patients and professionals across health and social care

Source:

Independent Commission for the Royal College of General Practitioners and the Health Foundation. Guiding patients through complexity: modern medical generalism [Internet]. 2011 [cited 2012 Jun 23]. Available from: http://www.rcgp.org.uk/policy/commission_on_generalism.aspx

2. The family practice of the future is a team practice

GPs and family doctors want and are increasingly having to work in family practice teams as well as in teams that include members of other professions (in particular health care assistants, nurses, physio-/ergotherapists, social workers etc.) and disciplines (other specialists, psychologists etc.). By providing patient health care as a team, GPs can meet the rising demands of caring for the chronically ill, while at the same time achieving a better work-life balance (part-time work/working in salaried employment). Even in single-handed practices, the number of which is sinking, cooperation in a (small) team and cross-practice networking are on the increase. Remuneration systems and incentives should not stand in the way of successful teamwork.

The benefits that can be achieved through teamwork demand new remuneration structures and, more specifically, the appropriate remuneration of all involved professions.

Even now, the majority of new practices being set up are taking the form of collaborations (APO Bank and Central Research Institute of Ambulatory Health Care: An Analysis of Business Startups by Doctors 2009/2010). Randomized controlled studies in German family practices demonstrate that case management provided for the chronically ill by health care assistants is well accepted and improves health care (Gensichen et al. 2009). Multi-professional and interdisciplinary cooperation is a central element of recommended models for primary care practices (Council of Experts 2009)

Sources:

APO-Bank und Zentralinstitut für die Kassenärztliche Versorgung: Existenzgründungsanalyse für Ärzte 2009/2010.

Gensichen J, von Korff M, Peitz M, Muth C, Beyer M, Güthlin C, Torge M, Petersen JJ, Rosemann T, König J, Gerlach FM; PRoMPT (PRimary care Monitoring for depressive Patients Trial). Case management for depression by health care assistants in small primary care practices: a cluster randomized trial. *Ann Intern Med* 2009; 151: 369-378

Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen: Sondergutachten 2009. [cited 2012 Jul 3]. Available from: <http://www.svr-gesundheit.de>

3. GPs and family doctors provide a comprehensive range of treatment options for all groups of patients

GPs and family doctors are the first port of call for most patients with somatic and psychosocial health problems. The provided services range from prevention, health promotion and early diagnosis of illnesses, through acute and long-term care in cases of mental and chronic illness, to palliative care. From children to the elderly, health care is provided to persons of all ages, professions and ethnicities.

According to Barbara Starfield (1998), the comprehensiveness of health care (i.e. provision to all population groups) is an important feature of good primary care. In Germany in 2007, the Gmünder Ersatzkasse health insurer reported that when seeking health care, the first point of contact of 93% of its members was in ambulatory care. Of these, the treatment rate among GPs and family doctors was 68% and among specialists ranged from 8% for urologists to 31% for specialist in internal medicine (Grobe et al. 2008).

Sources:

Grobe T, Dörning H, Schwartz FW. GEK-Report ambulante ärztliche Versorgung 2008. Gmünder Ersatzkasse (Hrsg.). St. Augustin: Asgard Verlag; 2008.

Starfield B. Primary Care. Balancing Health Needs, Services and Technology. New York: Oxford University Press; 1998.

4. DGP and family practice-based care requires a stable and supportive framework

Stable and supportive framework conditions are absolutely essential to the forward-looking development of GP-based primary care.

The following are particularly important:

- **Support for stable doctor/patient relationships and the assumption of specific responsibilities (e.g., via registration models)**
- **Support for a sensible, evidence-based range of services that are quality controlled (e.g., by means of a medication check), particularly in the care of the chronically ill**
- **Support for services provided by the non-physician members of the practice team (e.g., by specially trained health care assistants or VERAHs)**
- **Support for interdisciplinary cooperation agreements and networking with other service providers (including nurses)**
- **Support for local, easily accessible health care and emergency services**
- **A reduction in the number of physician contacts as these are very high in international comparisons (for example by means of capitation fees that are independent of the number of visits to the doctor, and of support for the discussion-intensive devotion of time to patients).**

It is necessary that patients 'belong' to a specific practice if responsibility for their health care is to be assumed, continuity of comprehensive GP-based care is to be ensured, and resources are to be used efficiently. International comparisons show that primary care-oriented health care systems show greater benefits for the population as a whole. In contrast to rigid access controls (gatekeeping), the function of the GP and family doctor should rather be as a consultant and gateopener whose function is to arrange alternative treatment possibilities where necessary. Even when family practices cooperate, it must remain possible to allocate an individual patient to his or her own personally responsible doctor.

It is DEGAM's view that most patients' health care needs should be met in the family practice. This ensures that specialists focus their attention on the health care for which they have received specialist training.

It is particularly important that an appropriate framework is established that provides the necessary conditions to support family practice-based health care that involves the whole practice team, especially in view of the growing number of chronically ill patients. Contracts for family practice-based health care (particularly in Baden-Wuerttemberg) have made it possible to implement some of the framework conditions that are needed. However, it cannot be expected that the entire potential of family practice-based health care (WHO 2008) will emerge until beneficial framework conditions are established for family practices both nationwide and by all health insurance funds.

Source:

WHO. The World Health Report 2008: Primary Health Care (Now More Than Ever) [Internet]. 2008 [cited 2012 Jun 26]. Available from: <http://www.who.int/whr/2008/en/index.html>

5. Family medicine is very important in family practice-based care

The provision of cross-generational health care that takes a patient's social context into account requires knowledge of his or her family environment. Family medicine as an integral part of family practice-based care demands inter-professional considerations be taken into account on a day-to-day basis (Hegemann et al. 2000). However, the focus is always on the patient, his or her living environment and its impact on health. In this respect, a relationship may exist with individual patients within their social context, as well as with the family as a whole and as a system (Buetow, Kenealy 2007, Himmel, Kochen 1998).

Family medicine is of central importance in a society that is undergoing change and forcing individuals and communities to face difficult challenges (migration, an ageing population, increasing social inequality, unemployment, poverty etc.). The family practice is both the focus and a reflection of these changes. The frame of reference of the family practice must therefore adapt to the social structures that make up society. This is no longer the classic basic or extended family but rather the patient's primary living environment. Nowadays, when treating several persons from the same family, GPs and family doctors come across families in the broadest sense when, for example, providing care for single mothers and their children, patchwork families, adolescents in crisis situations, caregivers looking after relatives, or when providing grief and palliative counseling. In comparison to other specialist fields and facilities, general practice thus has special opportunities and responsibilities.

Sources:

Buetow SA, Kenealy TW (Hrsg.). Ideological debates in family medicine. New York: Nova Science Publishers; 2007.

Hegemann T, Asen E, Tomson P. Familienmedizin für die Praxis. Stuttgart: Schattauer; 2000.

Himmel W, Kochen MM. Der familienmedizinische Ansatz in der Allgemeinmedizin. Dtsch Ärztebl 1998; 95(28-29): A1794-1797

6. In the future, GPs and family doctors will provide the majority of care themselves. Furthermore, they will coordinate treatment across various sectors and professional groups

GPs and family doctors provide qualified basic health care and additionally organize collaboration with specialists, hospitals, nursing and social services, as well as other health professionals and facilities in the community. They play a central role as coordinators and have an overview of all the health care received by their patients.

According to Barbara Starfield (1998), the coordination of treatment with other service providers within the health care system is one of four pillars that make up primary care. Well-organized coordination of health care is particularly important for the chronically ill. This group of patients nearly always requires treatment from a number of doctors. Unnecessary repeat examinations and errors increase in line with the number of persons treating the patient (Schoen et al. 2008). Efficient coordination can contribute towards increasing the quality of patient health care and lowering costs (Øvretveit 2011).

Sources:

Øvretveit J. Evidence: Does clinical coordination improve quality and save money? Volume 1: A summary review of the evidence. London: Health Foundation; 2011.

Schoen C, Osborn R, How SKH, Doty MM, Peugh J. In Chronic Condition: Experiences Of Patients With Complex Health Care Needs, In Eight Countries. Health Affairs 2008; 28(1, 2009): w1-w16

Starfield B. Primary Care. Balancing Health Needs, Services and Technology. New York: Oxford University Press; 1998.

7. GPs and family doctors encourage patients to independently and actively make use of their own resources

Whenever it is possible and makes sense and before turning to external measures and technologies, it is important to investigate in the broadest sense whether the desired results cannot be achieved at least as well by means of individual initiative and a change in the patient's behavior. Such changes would be supported by the doctor and would avoid the need to prescribe medications, and other remedies and aids, as well as avoid the use of technical procedures. GPs and family doctors would help patients establish and name their own health objectives and use their own salutogenic potential independently and actively in order to achieve them.

As has been correctly and repeatedly pointed out in family practice guidelines (DEGAM guidelines 2012, PMV research group 2012), but also in medication information sheets and guidelines on the prescription of drugs (Federal Joint Committee 2009), behavioral changes take priority and specific therapies should only be implemented when behavioral changes do not achieve the desired results or are not possible. In reality, this is rather difficult to achieve. It demands time, commitment and often a substantial amount of patience. Visible success is rarely attained as quickly as the administration of drugs would be expected to. However, the 'activation' of the patient strengthens his autonomy and often results in the utilization of fewer medical resources (Soukup et al. 1999, Adami et al. 2010). GPs and family doctors pay special attention to how the healthy can remain so and how the ill can regain their health (salutogenesis).

Sources:

Adami PE, Negro A, Lala N, Martelelli P: The role of physical activity in the prevention and treatment of chronic diseases. Clin Ter. 2010; 161 (6): 537-541

Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin. Leitlinien der DEGAM (insbesondere Nr. 2-4, 12 und 13). Frei verfügbar unter <http://leitlinien.degam.de/index.php?id=fertiggestellteleitlinien> (letzter Zugriff: 03.07.12)

Gemeinsamer Bundesausschuss. Richtlinie des Gemeinsamen Bundesausschusses über die Verordnung von Arzneimitteln in der vertragsärztlichen Versorgung (insbesondere § 8). Bundesanzeiger 2009, 49a. [cited 2012 Jul 3]. Available from: http://www.g-ba.de/downloads/62-492-610/AM-RL_2012-01-19_2012-05-01.pdf

PMV Forschungsgruppe. Leitlinien (insbesondere Diabetes, Fettstoffwechselstörung, kardiovaskuläre Prävention). [cited 2012 Jul 2]. Available from: http://www.pmvforschungsgruppe.de/content/03_publicationen/03_d_leitlinien.htm (letzter Zugriff: 02.07.12)

Soukup MG, Glomsrod B, Lonn JH, Bö K, Larsen S. The effect of a Mensendieck Exercise Program as secondary prophylaxis of recurrent low back pain: a randomized, controlled trial with 12-month-follow up. Spine 1999; 24: 1585-1592

8. Family practice-based care – the best protection against too much and bad medicine

Family practice-based health care increases patient safety as a result of individual and joint weighing up of the potential harm and benefits of specific diagnostic evaluations and therapies and thus helps to save resources by avoiding unnecessary medical procedures (so-called quaternary prevention) (Kühlein et al. 2010, Jamouille 2012). This entails the consideration of interpersonal events, a long-term treatment plan that involves the patient (participative decision-making) and the integration of all procedures to form a complete therapeutic concept.

A person's illnesses are seldom one-dimensional – there are generally previous events with first mild symptoms, risk factors for the illness and the individual's personal way of dealing with it that also have to be taken into consideration. Furthermore, people often have other illnesses (multimorbidity), as well as individual strengths and weaknesses that are important when resolving the question how the illness developed and the particular form it has taken.

This multidimensionality and the multimorbidity that often accompanies it should be well known to the attending physician as a result of previous interactions with the patient. It is only as a result of this knowledge that the doctor and patient can jointly make a considered decision as to the harm and benefits of a certain diagnostic evaluation or treatment. If care is not coordinated with other treating physicians, as well as considered decision-making on an individual basis where necessary, there is a danger of too much, too little or bad medical care. In order to carefully make such decisions, a trusting relationship between doctor and patient is essential. Such a relationship can only develop over time and as a result of numerous encounters between physician and patient.

Progress in the development of drug therapies makes it possible to treat a large number of illnesses with medications. Particularly when patients have several chronic illnesses, this carries the specific risks of polypharmacotherapy. Uncoordinated access to all kinds of doctors in private practice encourages the simultaneous treatment of an illness by various specialists. In themselves, individual drug prescriptions and over-the-counter medicines often make a good deal of sense. However the risks to individual patients are substantial in cases when several prescriptions are provided without any coordination by a central point of contact (Gaal et al. 2011, 6). The coordination of treatment and drug recommendations made by all physicians that are treating the patient can be provided by the family practice team. This raises the safety of a drug therapy, improves the care of the chronically ill in particular, and contributes towards targeting limited (financial) resources more efficiently (Gaal et al. 2011, 11).

Sources:

Abholz H-H, Wilm S. Entscheidungsfindung in der Allgemeinmedizin. In: Kochen MM (Hrsg). Allgemeinmedizin und Familienmedizin, 4. Aufl., Stuttgart: Thieme; 2012: S. 606-616

Gaal S, Verstappen W, Wensing M. What do primary care physicians and researchers consider the most important patient safety improvement strategies? BMC Health Serv Res. 2011; 11: 102

Gaal S, Verstappen W, Wolters R, Lankveld H, van Weel C, Wensing M. Prevalence and consequences of patient safety incidents in general practice in the Netherlands: a retrospective medical record review study. Implement Sci. 2011; 6: 37 and 37.2

Gareus I, Abholz H-H. Patientenpartizipation in der Hausarztpraxis. In: Rosenbrock R, Hartung S (Hrsg): Handbuch Partizipation und Gesundheit. Bern: Huber; 2012. S. 313-343

Jamouille M. [Internet]. Quaternary prevention. Prevention as you never heard before. [cited 2012 Jul 10]. Available from: <http://www.ulb.ac.be/esp/mfsp/quat-en.html>

Kuehle T, Sghedoni D, Visentin G, Gervas J, Jamouille M. Quartäre Prävention, eine Aufgabe für Hausärzte. PrimaryCare 2010; 10(18): 350-354

9. A trusting doctor-patient relationship is at the center of a family doctor's work

The relationship with the patient is largely determined by the doctor's attitude in terms of trust, empathy, openness and esteem. Such an attitude makes it possible to develop personal and trusting relationships and provide corresponding health care to the patient in the family practice – over the long-term where necessary.

Following a patient's medical history, perhaps throughout the whole of his or her life and across generations, makes it possible to take the psychosocial causes of an illness into account and to take an all-encompassing view of the patient that includes his social and family environment. This is a positive experience for both patient and attending physician and should be guaranteed in the team practice (Wilm, in der Schmittgen 2007). The freely chosen continuity of a relationship creates the conditions in which the family doctor can coordinate treatment well and motivate the patient. Barbara Starfield (1998) describes the long-term continuity of care as one of the main pillars of primary health care. In Germany, the first point of contact in the health-care system for 90% of the population and 96% of persons with chronic illnesses is the GP or family doctor, who also represents an important person of trust (van den Bussche et al. 2007). 77% of patients have been treated by the same doctor for more than five years (Koch et al. 2010).

The patient's and doctor's understanding of illness are important elements in this relationship and build the foundation for joint decision-making (Bahrs, Köhle 1989, Kamps 2004, Kamps, Harms 2010). In its current form, fee-for-service remuneration often creates poor incentives by encouraging technical examinations rather than time-intensive counseling. Encouragement to change behavior rather than undergo treatment involving drugs and other passive measures demands time, commitment and persistence. Visible success is rarely achieved overnight.

Amongst other things, the quality of family practice-based health care can be measured in terms of the extent to which patient-centered health care and an authentic manner make it possible to place the patient at the center of treatment (Bär 2009, WHO 2005). The family doctor is often not conscious of the influence of his or her understanding of illness on the course and results of the interaction; a constant process of reflection on this subject makes it possible to provide the individual patient with more appropriate health care (Kreher et al. 2009).

Sources:

- Bahrs O, Köhle M. Das doppelte Verstehensproblem – Arzt-Patient-Interaktion in der Hausarztpraxis. In: Neubig H (Hrsg.). Die Balint-Gruppe in Klinik und Praxis, Band 4. Berlin: Springer; 1989: 103-130
- Bär T. Die spontane Gesprächszeit von Patienten zu Beginn des Gesprächs in der hausärztlichen Praxis. Med Diss 2009. Berlin: Charité.
- Kamps H, Harms D. Die medizinische Theorie passt auf zwei Bierdeckel – Skizzen einer hausärztlichen Semiotik. Z Allg Med 2010; 86: 140-143
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- Koch K, Schürmann C, Sawicki P. Das deutsche Gesundheitswesen im internationalen Vergleich: Die Perspektive der Patienten. Dtsch Arztebl Int 2010; 107(24): 427-434
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- WHO. Preparing health care workforce for the 21st century. The challenge of chronic conditions. Geneva: WHO; 2005.
- Wilm S, in der Schmittgen J. Was ist der Kern der hausärztlichen Tätigkeit? PrimaryCare 2007; 7(29-30): 481-485

10. GPs and family doctors guarantee continuity in the doctor-patient relationship. When there are multiple symptoms and diseases, this helps to prioritize and identify intercurrent illnesses, and is an important tool when deciding on diagnostic evaluations and therapy.

General practice: the right health care at the right time and at the right place. The rising average age of the population and progress in medicine are raising the number of persons with chronic or multiple diseases. They are in particular danger of receiving too much, too little or bad health care. The integration and coordination of all treatments and treating physicians within the framework of long-term health care is an important task for the family practice. Family doctors are particularly suited to take on this role because they have comprehensive knowledge of the whole person in his living environment and can guarantee continuity of care beyond individual disease episodes.

The individualized and evidence-based concentration on the most important treatment procedures is only possible within the context of a trusting relationship between patient and doctor and a holistic approach involving broad-based responsibility and continuity of care (Freeman, Hughes 2010).

The continuity of family practice-based health care enables new health problems, deterioration and complications in existing diseases and the side effects of therapeutic measures to be detected early and averted (Reeve 2010).

This is a special challenge for family doctors: i.e., to be able to provide assistance when several issues require advice during one consultation. In this context, it is necessary to weigh up the possible benefits and harm of specific interventions for single health complaints, to check their appropriateness for the patient and to agree with the patient and relatives on an individual course of action. Continuity of care as the basis of a trusting relationship between patient and doctor is necessary if this is to be achieved.

Sources:

Freeman G, Hughes J. Continuity of care and the patient experience. London: The Kings Fund; 2010.

Reeve J. Interpretive medicine: Supporting generalism in a changing primary care world. Occas Pap R Coll Gen Pract. 2010; 88: 1-20, v.

11. Only general practice can guarantee conveniently located, nationwide and low-threshold health care for the whole population

Patients want single-source, conveniently located health care. GPs and family doctors can solve the majority of all patient health concerns quickly and simply and to the satisfaction of their patients (Green et al. 2001). The autonomy of the elderly can be maintained by providing conveniently located, family practice-based health care.

Continuous and conveniently located health care can generally be provided without recourse to specialized technical examinations. It is typical for general practice that when advice is being sought for several health issues or various organ areas are concerned, health care can be provided for all the problems at the same time. Studies have demonstrated that this can only be provided cost-effectively by qualified GPs and family doctors (Starfield 2012, Friedberg et al. 2010).

Nationwide family practice-based health care must be supported and further developed in both urban and rural areas (cooperative models, branch and group practices, flexible working hours).

Sources:

Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence on quality and costs of health care. *Health Aff (Millwood)*. 2010; 29: 766-772

Green LA, Fryer GE Jr, Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. *N Engl J Med*. 2001; 344: 2021-2025

Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. *SESPAS report 2012. Gac Sanit*. 2012; 26: S20-26

12. The family practice is a place that reduces social injustice

The conveniently located, continuous and socially low-threshold accessibility of the family practice has a socially integrative function in times of serious socio-economic disparities. In this respect, the doctor can and should be a defender of disadvantaged persons with health problems.

Poverty, social isolation and, in particular, confrontations with social inequality, have a significant impact on the development and course of illness. In Germany, for example, the disparity in life expectancy between the highest and lowest social classes is 8 years for men and 6 years for women. There are similar differences in the frequency of chronic illness and in early retirement. These discrepancies are not falling but are actually on the increase.

Poverty and social isolation cannot be cured by working as a family doctor. But GPs and family doctors are close to their patients and should be advocates for a reduction in the social divide within society. The family practice should thus be a place where respect and equal opportunity are the rule and a feature of personal interactions.

At the same time, the 'inverse care law', as it is referred to internationally, exists in Germany as well. Most GPs and family doctors work in the regions (particularly wealthy urban districts in metropolitan areas) in which they are least needed. The poorer and thus more at danger of becoming prematurely ill and of mortality a population is (particularly in 'poorer' living quarters and in rural areas), the worse the provision of health care there tends to be.

DEGAM is therefore an advocate of an allocation of health care resources that meets the needs of the entire population.

Sources:

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Gregory IN. Comparisons between geographies of mortality and deprivation from the 1900s and 2001: spatial analysis of census and mortality statistics. *BMJ* 2009; 339: b3454

Klose J, Rehbein I. *Ärztatlas 2011*. Daten zur Versorgungsdichte von Vertragsärzten. Wissenschaftliches Institut der AOK (WIdO). Berlin; 2011. [cited 2012 Jul 3]. Available from: http://www.wido.de/fileadmin/wido/downloads/pdf_ambulaten_versorg/wido_amb_pub-aerzteatlas2011_0511.pdf

Marmot M. Achieving health equity: from root causes to fair outcomes. *The Lancet* 2007; 370: 1153–1163

Shi L, Starfield B, Kawachi I. Income inequality, primary care, and health indicators. *J Fam pract* 1999; 48: 275-284

Wilkinson R, Pickett K. *The spirit level. Why equality is better for everyone*. London: Penguin; 2010.

13. GPs and family doctors are involved in addressing the health concerns of their communities

GPs and family doctors integrate and coordinate individual and regional health objectives in their communities. As they are familiar with the region and are in a position to cooperate with others, family practice teams can have a real influence on salutogenic, preventive, rehabilitative and self-help structures, such as bicycle paths, jogging clubs, food selection, school health promotion, social networking or exercise groups for the elderly.

Using the available regional infrastructure and institutions (town councils, businesses, welfare organizations, church councils, health care facilities, outreach services, media etc.), through cooperation with other health care professionals and social services personnel, and by pooling competing resources, measures aimed at promoting health care can help individuals and groups in their living environments within the community to develop their health and implement health objectives in everyday life (Wiesemann 2006). Family practice work can thus include both individual health care and public health concerns.

Sources:

Barnes KA, Kroening-Roche JC, Comfort BW. The developing vision of Primary Care. N Engl J Med 2012; 367: 891-93

Wiesemann A. Hausärztliche Gemeindemedizin. In: Kochen MM (Hrsg.). Allgemeinmedizin und Familienmedizin. 4. Aufl. Stuttgart: Thieme; 2012. S.274-280

14. GPs and family doctors are specialists in preventing life threatening conditions and dealing with ambiguous symptoms

As a result of easy and low-threshold access, GPs and family doctors work in a 'low prevalence' area in which severe illnesses are rarer and unspecific symptoms that do not immediately permit a clear diagnosis more common. The decision-making process must therefore take a high level of uncertainty into account. This makes special demands on the communication process and decision-making competencies.

Low-threshold access to the family practice makes it the first port of call for health problems. As a result GPs and family doctors often have to deal with undifferentiated patient concerns. At this stage it is often impossible and unnecessary to commit oneself to a clear medical diagnosis. GPs and family doctors develop instruments and techniques to deal with diagnostic, prognostic and therapeutic uncertainty. Heuristics that are appropriate to the practice situation, and scientifically evaluated decision-making aids, as well as the ability to strike a balance between openness and transparency on the one hand and dealing with fear and concern on the other, belong to these instruments and techniques. The family practice is the ideal location for this because patients are often treated there over a long period of time. This combination of factors makes it easier to share decision making with the patient. The family doctor shows considerable skill in pursuing an active and consciously managed policy of cautiously keeping options open, while recognizing and preventing life threatening conditions. By means of effective communication, GPs and family doctors can share moments of uncertainty with the patient and by means of appropriate advice and care protect him from excessive diagnostic evaluation and too much and/or bad therapy. At the same time, they are using our society's resources efficiently.

Source:

O'Riordan M, Dahinden A, Aktürk Z, Ortiz JM, Dagdeviren N, Elwyn G, Micallef A, Murtonen M, Samuelson M, Struk P, Tayar D, Thesen J. Dealing with uncertainty in general practice: an essential skill for the general practitioner. *Qual.Prim.Care* 2011; 19: 175-181

15. All students of general practice should receive early and continuous training in academic teaching practices during their studies

DEGAM advocates orienting medical studies towards the realities of health care more than is currently the case. All students should therefore repeatedly come into contact with family medicine throughout their studies. Besides improving general medical competence, this condition must be fulfilled if the hearts and brains of young doctors are to be convinced of the attractions of family practice.

In addition to gaining skills and experience in the tasks and work that are typical for the family doctor, it is important to communicate to medical students the joy that is to be had in this multifaceted and exciting profession. General practice is confronted with various stereotypes and prejudices, both from students and representatives of other medical disciplines. Students must find out as early on in their studies as possible that general practice is more than just the sum of the slimmed down essentials of other disciplines and that general practice is just as modern as the organ fixation that is typical of high-tech medicine. General practice block work placements and a mandatory general practice element during the practical year are both important if this is to be achieved and should be integrated into medical studies. By getting to know this central area of health care, students will gain a better understanding of how family practices function as well as their limitations. It is therefore particularly important for those students who will later be working in other disciplines and areas of health care.

General practice has millions of advocates in the general population who are generally silent during public debates (for example on the introduction of a mandatory quarter dedicated to the study of general practice during internships). Policymakers and stakeholders in the health care system must recognize that general practice is not only extremely well suited to providing high-quality basic health care but also absolutely essential.

Source:

Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin. Positionspapier zum Bedarf an humanmedizinischen Studienplätzen und zur Förderung des hausärztlichen Nachwuchses an deutschen Universitäten und in der Versorgung [Internet]. DEGAM-Positionspapier vom 21.01.2011. [cited 2012 Jun 24]. Available from: http://www.degam.de/fileadmin/user_upload/degam/Studium_und_Hochschule/100920_Positionspapier_Prof_Baum.pdf

16. General practice is the core subject in medical studies

Medical studies aim to communicate basic medical skills that are supposed to enable students to later be able to specialize in all disciplines. It is essential that students learn, for example, practical skills such as how to perform a physical examination, as well as communication and interactional skills. In view of the increasing amount of sub-specialization – especially in university hospitals – general practice is ideally suited to the communication of these skills. The participation of GPs and family doctors in the shape of academic teaching practices is explicitly welcomed.

The health care needs of the population and the current burden of disease must be adequately reflected in medical studies: a large number of students will later work either in family medicine or the outpatient sector, or they will regularly cooperate with this area of health care (see German Medical Council). These are also good reasons for increasing the representation of general practice in studies of medicine.

Special skills are required to deal with the wide spectrum of reasons for consulting a doctor for advice in primary health care, and the long-term care of the chronically ill. For this reason, general practice is not simply a sum of specialist disciplines or a cross-section ('a little bit of everything') but rather involves its own way of thinking and its own approach, and this is something that can only be taught by GPs and family doctors. The broad range of reasons to seek advice and the individual care of patients of all ages and from all social classes means that work as a GP or family doctor is intellectually and emotionally challenging and remains so for the whole of a lifetime. For the implementation of general practice as the core subject in medical studies it is essential that:

- Fully functioning and well equipped departments or institutes are established in all German medical faculties,
- Practices that offer students the opportunity to absolve a practical year and the students themselves should both receive financial support,
- A longitudinal curriculum in general practice is set up that extends from the beginning of the course until the practical year is completed (see Uni-wh and Charité).

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17. GP/Family doctor = Specialist in general practice

General practice is more than just the sum of individual specialist disciplines. Even internal medicine only covers a good third of reasons to consult a GP. Thus neither purely clinical nor internal medicine training alone is sufficient to meet the demands of work in a qualified family practice. It is therefore necessary that GPs and family doctors have spent a substantial portion of their studies working in a family practice.

Epidemiological studies involving more than 100,000 patients have shown that an attempt to allocate reasons family doctors in general practice are consulted to individual specialist areas results in the following picture: Surgery 7%, Dermatology 8%, Gynecology 4%, Ear, nose, throat 3%, Internal medicine (all priorities) 32%, Neurology 6%, Ophthalmology 4%, Orthopedics 26%, Pediatrics 14%, Psychology 9% and Urology 4% (Multiple assignments, rounded, in alphabetic order, Laux et al. 2010). Specialist training in hospitals where patients in Germany stay for an average of 6-8 days includes no preparation for the central task of providing long-term care for the chronically ill (continuous medication management, motivation for patient and relatives, long-term monitoring of medication and progression of illness etc.). The exceptional conditions involved in the provision of care during home visits or in retirement and nursing homes are also alien to hospital clinicians with no practice experience. The same is true of recommended screening examinations, measures to promote health that take the patient's living environment into account, or prevention such as routine vaccinations, as well as the number of diseases the GP confronts (e.g., simple infections, mood disorders), that are common in the primary care practice for outpatients but which, as a rule, are virtually never found in hospitals.

On the basis of the aforementioned epidemiological data for practices and related job analyses in general practice, training in a family practice is absolutely essential. Only then will qualified general practice specialists be in a position to deal independently and conclusively with around 90% of all the issues that lead patients to consult their doctors. Specialization in a hospital is simply not enough. Throughout the world, the qualification needs of general practitioners and family doctors are undisputed; only qualified GPs and family doctors are permitted to set up in general practice in those European countries that have an efficient primary health care system.

Sources:

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18. Combined specialist training in general practice is essential if high quality basic health care is to be guaranteed for the whole population

All specialist training must ensure that skills and attitudes are learned that prepare participants as well as possible for their work as a GP or family doctor. The necessary skills can best be taught in the form of structured combined specialist training for specialists in general practice. With its 'combined specialist training plus' (Verbundweiterbildung plus), DEGAM is developing a comprehensive, subject-specific concept that entails coordination in terms of both content and organization (Steinhäuser et al. 2011, DEGAM 2009). The implementation of these programs should be externally financed and provided nationwide (Plat et al. 2007).

The aim to provide comprehensive knowledge of primary care requires subject rotation, so that participants get to know rare disease progressions, as well as other specialist disciplines. At the same time, it is necessary that a specific skill-based curriculum is absolved by the specialist in general practice (general practice competence center).

It is hoped that the extra work currently involved in frequently changing location, the frequent interruptions, as well as the isolation of GPs and family doctors undergoing specialist training, can be avoided by providing combined specialist training in one block and from one source. The additional structured external supervision and organization of theoretical units (tutorials, mentoring) requires – as is standard practice in other European countries – external financing (DEGAM 2009, Plat et al. 2007). GPs and family doctors undergoing specialist training should be released from work during this period. Furthermore, GPs and family doctors in advanced training should be remunerated appropriately.

The specialist qualification attests to the knowledge and skills that have been learned during specialist training and no further courses involving additional sub-specialization are necessary (DEGAM 2011).

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19. Continuing medical education for GPs and family doctors and their practice teams is independent of industry, evidence- and case-based, interactive and inter-collegial

General practice and family medicine have very specific characteristics such as multimorbidity among patients, work in a low-prevalence area or biopsychosocial disease models. Traditional continuing medical education formats involving lectures from 'specialists' who are unfamiliar with general practice are therefore only of limited suitability for improving and maintaining the skills required by GPs.

For this reason, the evidence-based learning with and from one another that has been successfully established in medical quality circles (peer learning, internship as observer) should be employed more often in CME. Furthermore, the growing responsibilities being adopted by non-physician health professionals mean they should be more tightly integrated into continuing education programs.

Following the example of U.S. and Australian medical associations, DEGAM advocates that educational events that are sponsored by the pharmaceutical industry should not be officially recognized.

As was presented in the resolutions of the conferences of federal state health ministers in 2002 and 2004, CME in Germany is underdeveloped in some areas and urgently needs to be reformed (Donner-Banzhoff et al. 2005).

The increase in the number of elderly, multimorbid patients is confronting family practice-based health care with unprecedented challenges (Wise 2011).

Commercial providers of education programs generally work closely with industry, communicate the views of specialists, and rarely have a great deal to do with the problems facing GPs and family doctors. Avoidable conflicts of interests influence an individual's judgment in an inappropriate manner and therefore have no place in medical education.

The multi-professional approach to CME that was recommended in the Advisory Council on the Assessment of Developments in the Health Care System's 2009 special report should, for reasons of sustainability, be supplemented with the introduction of mandatory peer interactions (Fraser 2004).

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20. General practice research scientists prefer to work on practical questions related to their everyday work

The definition of research topics and the focus of research is a complex process. In current medical research it is generally the interests of commercial developers (e.g., the pharmaceutical industry), the requirements of regulatory authorities, and biomedical objectives that have the greatest influence. It has repeatedly been lamented that questions that are formulated by clinicians are frequently not of great relevance to general practice (Tunis et al. 2003). General practice research on the other hand generally deals with the everyday problems that concern family medicine, and its results mostly have direct practical relevance.

GPs and family doctors can look back on a long-standing tradition of practical research; this began with the GPs and family doctors that systematically investigated the morbidity of their practice populations (Braun 1988, Pickles 1983). Meanwhile it has been accepted that the results obtained in specialized secondary and tertiary health care cannot simply be transferred to the field of general practice. It is necessary that general practice research scientists conduct their own clinical research in their own way.

In recent years, health services research has been strengthened in Germany, not least as a result of public sector funding, whereby the scope, research questions and range of methods deployed have been defined (Donner-Banzhoff et al. 2007). However, health services research is regarded as of less importance than basic and clinical research in most of the disciplines that conduct university research; in general practice, it is not only clinical research but also health services research that is at the very core of research efforts. This explains the head-start that has been achieved in terms of general practice skills that is, for example, reflected in the number of competitive interdisciplinary invitations for research proposals that has led to a substantial increase in recent publication activity (Schneider et al. 2012).

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21. General practice research takes place throughout the world – With it the knowledge base for GP treatment is expanding

There are currently more than 200 university research departments worldwide that are active in the field of general practice, and in Germany 12 such departments systematically conduct practice research projects and publish their results internationally. They work with a network of qualified academic research practices that guarantee both proximity to existing health care and guarantee validity. Public sponsorship (see German Ministry of Education and Research, BMBF) and the status of family medicine within the health care system are important factors determining the development of strong primary care research. The latter point is amply demonstrated by the fact that the leading countries in general practice research generally have a strong family medicine base (e.g. The Netherlands, Scandinavia, Great Britain (Glanville et al. 2011)).

The following are examples of research findings that were gained in areas that are relevant to health services research (together with examples of publications from German university research in general practice):

- Practice-based interventions (Gensichen et al. 2009, Rosemann et al. 2007, Altiner et al. 2007)
- Adjustment heuristics in diagnostic evaluations (Bösner et al. 2010)
- Decision aids (Krones et al. 2008)
- Medications (comparative effectiveness trials) (Bleidorn et al. 2010)
- Different types of health care (Miksch et al. 2010)
- Disease etiology, prevalence and progression (Sczепanek et al. 2011, Scherer et al. 2007)
- Disease perceptions and concepts (Altiner et al. 2004)
- Utilization and distribution of cases (Laux et al. 2008)

Scientific results from general practice research are published in general medical journals (e.g., British Medical Journal, Dt. Ärzteblatt), and in journals that specialize in general practice (e.g., British Journal of General Practice, Zeitschrift für Allgemeinmedizin).

Particular attention needs to be paid to the implementation of research findings in standard care. Although guidelines are now generally accepted as an instrument to promote the implementation of such findings, it is only the DEGAM guideline program that insists on testing the results in practice. Major cluster-randomized trials have been conducted in Germany to evaluate the efficacy of the implementation of guidelines (Becker et al. 2008).

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22. GPs and family doctors play a pioneering role in promoting quality in health care

Patients have a right to high quality and safe health care. Systematic quality promotion in the family practice can help ensure they receive it. German GPs and family doctors were the first to take up the initiative and introduce and evaluate new concepts such as quality circles, practice guidelines and error reporting and learning systems. To achieve improvements in health care (and help determine the content of family doctor service contracts), quality management systems that are tailored to take into account the needs of family doctors, as well as quality circles that work with feedback, are supported by facilitators, and use prescription data, are particularly important.

As early as the beginning of the 90s, general practice research adapted several elements for use in the field of family medicine and was thus the first professional group in Germany to introduce systematic elements for quality management in health care (Gerlach 2001, Grol, Grimshaw 2003). In Germany, these took the shape of quality circles with feedback elements (Bahrs et al. 2001, Wensing et al. 2004), quality indicators, DEGAM guidelines, the error reporting and learning system (jeder-fehler-zaehlt.de) that is supported by DEGAM, as well as the quality management system European Practice Assessment (EPA) that is designed specifically for family doctors (Szecsenyi et al. 2011). Family practice-focused development, multi-perspective assessment including a practice visit, the use of benchmarking databanks and constant support in the implementation of quality objectives are all exclusive features of future-oriented quality management systems for family practices.

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23. DEGAM aims to make the quality of family medicine visible to the public through the use of quality indicators, quality management and guideline evaluation. DEGAM has reservations about a direct link to remuneration systems.

The desire to optimize the quality of health care lies behind the concepts of quality assurance, quality indicators and pay-for-performance (p4p). The implementation of internal quality management is enshrined in social legislation (§ 135a SGB V). The development of evidence-based quality indicators permits, in particular, a comparison between the different levels of health care and can improve the quality of family practice-based health care. The scope of application for quality indicators is broad and includes quality management in specific regions and practices. Furthermore, additional emphasis is currently being placed on quality indicators within the DEGAM guideline program. It should be borne in mind that cross-facility and cross-sector indicators also need to be systematically developed and cannot simply be transferred from other countries to the circumstances existing in German health care. There is also a danger that the requirements of p4p systems may come into conflict with the personal interests of patients and that it may lead to deterioration in the continuity of doctor-patient relationships (Campbell 2009).

Indicators can provide the basis for quality criteria and pay-for-performance (p4p) and thus not only for the control of funding but also for health care services in general. However, no reliable study evidence is currently available that indicates that p4p has a continuous positive impact on the quality of health care, i.e., in terms of improved quality of life, or a fall in morbidity or mortality. Initial positive effects can disappear and the starting level be returned to when p4p support is withdrawn. On the other hand, when indicators are linked to p4p, it can result in adverse effects such as (additional) discrimination against care for multimorbid patients, patients with rare diseases and socially marginalized groups, and it should therefore be viewed critically. In view of the desired control effects and limited resources, such indicators cannot be defined in medical terms alone, but must be developed and implemented with the help of clearly formulated, prioritized, and socially acceptable requirements. Before p4p is introduced, it is essential that a parallel comparison of expected effects is conducted.

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24. GPs and family doctors attach importance to independence of external service providers and industrial interests

GPs and family doctors are sometimes courted in the hope they will help other health care service providers to increase their gains. The deployed strategies are generally very subtle and difficult to recognize. DEGAM makes a point of rejecting funding by pharmaceutical companies.

As referrers and prescribers, GPs and family doctors are a very interesting target group. Consequently, they are the focus of many attempts to court them, for example by means of free magazines (Becker et al. 2011), sponsored training events, visits by pharma representatives, presents etc. Every GP and family doctor should pay close attention to the extent to which it may be possible to influence his or her behavior. The market for medical training is strongly influenced by producer interests. Voluntary self-control fails in this field and medical associations cannot control the confusing mass of events on offer. Commercial providers of training events often work closely with producers, generally communicate their own views and are rarely interested in the concerns of family medicine. The so-called pharma codex of the Federal Association of the Pharmaceutical Industry (BPI 2011) with its undertaking to "to keep advertising measures to an appropriate level" and to combat unfair competition is to be welcomed, as is the disclosure of possible conflicts of interest in all publications and by influential officer holders. For the same reasons, DEGAM makes a point of rejecting all funding by pharmaceutical companies. DEGAM Congresses are therefore completely 'pharma-free' and the *Zeitschrift für Allgemeinmedizin* (German Journal of General Practice) does not accept advertisements from pharmaceutical companies.

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Address:

DEGAM-Bundesgeschäftsstelle
Goethe-Universität, Haus 15, 4. OG
Theodor-Stern-Kai 7
60590 Frankfurt
Tel.: 069 - 60 00 72 45
Fax: 069 - 68 97 46 02
E-Mail: geschaeftsstelle@degam.de

The DEGAM positions on the future are available for download on the Association's website (www.degam.de).