Why German doctors enjoy British medicine

Marcus Simmgen

Marcus Simmgen
MSc MRCP(UK),
Wellcome Trust
Research Fellow,
Imperial College,
London

Clin Med 2004;**4**:57–59

ABSTRACT – Why do substantial numbers of German doctors come to work in the UK? Nearly 5,000 positions are vacant in Germany, yet around 350 new General Medical Council registrations are granted annually to these doctors. The UK is an attractive place to work due to opportunities for structured professional training, improved conditions and pay since the 'New Deal', and to the experience of living in a foreign country. This article compares and contrasts elements that affect a hospital doctor's working life in both health services, highlighting the strengths of the NHS that are easily overlooked in the current highly critical climate.

KEY WORDS: European doctors, General Medical Council registration, German doctors, medical workforce, National Health Service, New Deal, personal development, professional training

Criticism of the NHS is commonplace in the UK: patients are concerned about waiting times and outcomes of their treatment, and many doctors are unhappy with their training and working conditions.

Yet, 2,350 German doctors are currently registered with the General Medical Council (GMC), the largest group of European doctors in the UK. The peak influx occurred in 1996, with over 900 doctors registering that year. More than 350 partial and full registrations have continued to be granted annually since 1999 (Fig 1). In the light of a World Health Organization survey about healthcare efficiency where the UK came 24th, but Italy, France and Spain made it into the top ten (incidentally, Germany was 41st),[1] some may wonder what continues to attract German doctors to come and stay in the UK. I am one of those doctors and I feel it is time to say publicly what I have found praiseworthy in the UK medical system. This article is therefore based largely on my own experiences. I believe working in the NHS has much to be commended that is too often taken for granted, but I hope I am forgiven for some inevitable generalisations.

Professional development and standards

Wherever I have worked in the UK, I have been conscious of a generous desire to hand on experience and knowledge in the encouraging and informal environment that generally prevails here. Several levels of educational supervision are available to doctors in training through the tiered structure of clinical teams. Most British doctors strive to be memorable teachers to the next generation and take pride in their ability. This appears to be rooted in their personal experience as medical students and is continued throughout the medical career. By comparison, the hospital environment in Germany is harsher with a more competitive attitude. Senior house officers (SHOs) and even pre-registration house officers (PRHOs) are put at an early stage on rosters for on-call duties without having middle grade staff on site. Asking for help in Germany tends to be considered an admission of lack of knowledge and thus creates barriers. In the UK, advice from even very distinguished doctors is easy to obtain and there is rarely any hesitation in engaging in an educative conversation.

The problem-orientated approach of medical education in the UK is rewarding from early on as the knowledge gathered can often be readily applied to clinical practice. This is true for both bedside teaching and practical procedures. The adage of 'see one, do one, teach one' is not just old but very much alive and encourages involvement, thus motivating further understanding and practice. This differs from German medical training which focuses mainly on theory – with much less practical application left until near the end of the course. Over the past few years several German universities have recognised this problem and are implementing reforms modelled on the British system.

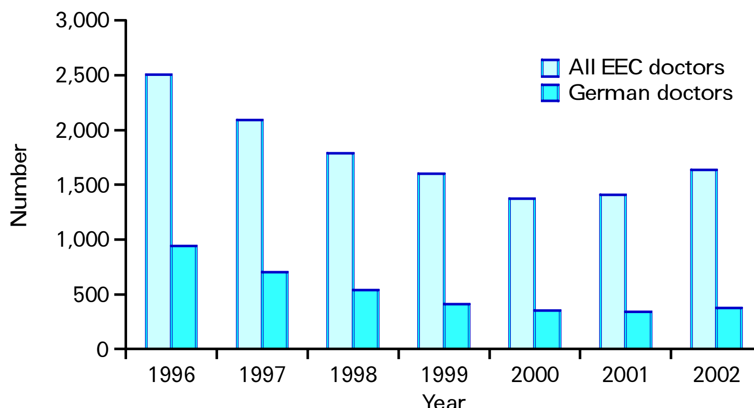

Fig 1. The number of registrations (partial and full) granted by the GMC to all EEC doctors vs doctors qualified in Germany, 1996–2002 (source: General Medical Council (personal communication), 2003).

Medical training in the UK is intended to provide exposure to varied medical practice before specialisation. The frequent change of posts during the early years offers an opportunity to try out different specialties, different hospitals and different regions of the country. This experience informs the decision to select a certain speciality, gives the satisfaction of acquiring a working knowledge of other subjects, and ultimately benefits patients. In Germany, specialisation can begin immediately after qualification. There the aim is to secure a permanent position in one department with full postgraduate training approval. Most doctors will only ever have worked in a few hospitals and have limited exposure to different case mixes and styles of work.

In the UK, educational meetings are well attended. PRHOs and SHOs have their own weekly in-hospital meetings, and specialist registrars (SpRs) a monthly regional training day at which attendance is usually compulsory. A generous allocation of time and a ring-fenced fund for designated postgraduate study leave is intended for candidates to attend preparatory courses for postgraduate examinations. Experienced colleagues will frequently offer spare time for focused coaching. Such study leave arrangements are unknown in Germany as there is no equivalent of the membership exam and most courses have to be funded by the trainee.

The reforms of the junior doctors' training structure in the UK reflect a full commitment to postgraduate education. Changes to working hours have prompted reviews of existing PRHO training arrangements; the SHO grade is the focus of continuing efforts at reform;[2] and a structured curriculum to achieve a specialist degree was implemented in 1997. An educational supervisor is allocated to PRHOs and SHOs during their basic medical training and regular appraisals are required. The annual 'in-training assessment' for SpRs ensures that any gaps are recognised early. The aim of these reviews is to help the trainee and offer further opportunities rather than blame. Primary responsibility for appropriate exposure to training lies with the Deaneries and the Joint Committee on Higher Medical Training rather than the individual.

By contrast, German postgraduate training has no structured regular external supervision. Heads of hospital departments are approved for the supervision of a part or all of the period of specialist training. The rotation through relevant departments and sufficient clinical exposure is arranged within and usually limited to one hospital. The approved departmental head decides on the training arrangements and hence much depends on his/her goodwill. Less favoured doctors may struggle for years to complete their required 'catalogue' of interventions, which can lead to tensions and jealousy among colleagues. The trainee is considered responsible for his/her own progress, with an exit exam at the end of specialisation aimed to guarantee a uniform standard of training.

In the UK, the Deaneries actively facilitate flexible or part-time training through direct funding of posts, a well-recognised scheme to attract and retain doctors through changes in personal circumstances. In Germany such family-friendly positions are scarce, as there is no special financial support for their creation. The UK has much improved its quality control of the provision of medical care. Public discussion accelerated by medical scandals has sparked changes in many areas. Individual clinical governance and audit practice are now important aspects of a doctor's working life and the introduction of quintannual revalidation has been welcomed by the great majority. New institutions such as the National Institute for Clinical Excellence and the Commission for Health Improvement are, despite some valid criticism, changing the public and professional perception of quality assurance in medicine. Similar ideas are just beginning to emerge in Germany but there are no comparable public bodies in place.

Key Points

- **There are 2,350 German doctors currently registered with the General Medical Council**
- **Scarcity of posts in Germany is no longer the main reason for moving to the UK**
- **The professional attractions of the UK system are an encouraging atmosphere with hands-on, supervised learning and well-organised postgraduate training courses**
- **The systematic reduction of junior doctors' hours, an increased transfer of routine duties to other appropriate healthcare professionals and better pay during the early years are also appealing**
- **The UK offers the adventure of being in a foreign country but with a familiar language**
- **The limitations of the NHS mainly involve inadequate facilities for delivering patient care**
- **Most of those who do return to Germany found the experience of working in the NHS far better than its reputation had suggested**

Working conditions and pay

The effective reduction of working hours across the grades in line with the 'New Deal' is gradually nearing completion. Although its full implementation required the imposition of financial fines on hospital trusts, the reduction of junior doctors' hours of work was helped by continued public interest. Research is being conducted as to how the changes can be best implemented.[3] This experience should benefit the UK when European legislation limits hours later this year. German doctors spend as many hours at work as their British colleagues. However, to achieve cost savings many hospitals have resorted to reducing full-time posts to part-time with a proportional reduction in pay. The workload remains the same, however, so extra work time is expected to be given gratis by the employee.

In the UK, a significant part of doctors' routine workload has been transferred to general nurses, specialist nurse practitioners, night managers and ancillary staff. German doctors spend a large proportion of their time doing phlebotomy, cannulation, first administration of intravenous drugs, blood transfusion,

ECG recording etc, as these tasks continue to be seen as primarily medical.

The length of clinic letters and discharge summaries in the UK are kept to a concise minimum due to the shortage of valuable secretarial time. Clinical coding is left to a dedicated department. In Germany, as hospital funding is now based on diagnosis-related groups and increases with details of a patient episode's coding, doctors have to spend many hours a week on this business-orientated activity.

Doctors' pay is significantly higher in the NHS during the early years of practice. In Germany, the current basic pay for a PRHO is 14,000 (£10,000) with 10% less in the Eastern federal states, and without the additional benefit of free accommodation. (In the UK, a PRHO's basic pay is £19,000.) At SHO and SpR level the basic pay is comparable to the UK with regional variations. In 2003, the salaries of hospital doctors rose by 2.3% in Germany and by 3% the UK. Cost pressures led to a 'zero pay rise' for non-hospital-based doctors being publicly debated in Germany earlier this year.

Personal rewards

Presumably due to the UK's long tradition of taking in overseas doctors, an overall welcoming and supportive atmosphere has developed in the NHS, conducive to both learning and enjoyment of work. A liberal attitude of 'live and let live' fosters the development of a personal style of work often with an internationally mixed team. Support and advice are available not only at the professional level but also at a personal one. Senior colleagues are generous with their time when asked for career advice, and often a personal bond forms that persists long beyond the next change of post.

The medical hierarchy in the UK appears quite relaxed. Different grades usually go hand in hand with different levels of experience and competence, and thus impart authority. The individual roles within a team are implicitly understood and need no underlining. The option to become a consultant is in principle open to everyone. In Germany, the hierarchy is pyramidal in structure with a single head of department directing other fully qualified specialists. This makes the competitive element more prominent, with frequent reminders of the 'pecking order' to those on the lower rungs.

Outside work, the experience of a (not all that) different culture and society in a foreign language is exciting and very rewarding. Tolerance and humour permeate most daily interactions, are actively cultivated and make life very tolerable.

Limitations of working in the UK

The initial need to adjust to a different healthcare system and language are generally no more than a temporary obstacle. Many German doctors have already had a glimpse of British hospital life during an elective period or have actively prepared themselves in other ways for the transition.

More permanent is the frustration of having to work with poorer quality equipment or inefficiencies within the NHS. For years there has been a comparative lack of investment and it shows. Many hospitals are in some state of disrepair and as a result the environment appeals to neither patients nor the workforce. Limited use of information technology, a frailty of other types of infrastructure and an adherence to the nine-to-five working day often contribute to inefficiencies in the system. The experience of long waits for inpatient investigations that are readily available in German hospitals can be disheartening. During German postgraduate specialist training many doctors have become competent to perform ultrasound-based investigations themselves, but access to such equipment is usually unavailable in the UK. British colleagues who have to endure these conditions are a source of consolation, however.

The frequent change of posts may damage still fragile social roots, particularly during the early years of practice. Sometimes several moves across the UK are required and the impact of a simultaneous change of team, working and perhaps social environment can be substantial.

Once the thrill and challenge of living in a different country begin to fade, one begins to reassess other aspects of life. Relationships with family and friends in Germany inevitably change while working and living abroad. Some personal compromises can be hard to sustain. New acquaintances may not always compensate for this and a proportion of German doctors return home after a while. But most would agree that working in the UK was a valuable experience.

Summary

German doctors form the majority of foreign European doctors in the UK. Scarcity of jobs is no longer the main reason for venturing across the Channel, but many other aspects of working in the NHS are proving attractive. These include systematic postgraduate training, recently improved working conditions and pay, and opportunities for personal development. Such advantages are easily overlooked amid the near universal criticism of the NHS as an employer. In Germany, with a third of hospitals actively considering introducing waiting lists because of a shortage of medical staff,[4] much could be learned from the British approach.

References

1 Evans DB, Tandon A, Murray CJL, Lauer JA. Comparative efficiency of national health systems: cross national econometric analysis. *BMJ* 2001; **323**(7308):307–10.

2 Donaldson, L. *Unfinished business: proposals for reform of the senior house officer grade.* London: Department of Health, 2002.

3 Cass HD, Smith I, Unthank C, Starling C, Collins JE. Improving compliance with requirements on junior doctors' hours. *BMJ* 2003; **327**(7409):270–73.

4 www.bundesaerztekammer.de/10/005Arztzahlen/01Zusammenfassung.html (accessed 6 Sept, 2003).