Medical education should serve the needs of the respective society and its health care delivery systems. It should also be in congruence with the legal frameworks as well as with quality assurance standards. All stages of medical education need reflection and permanent adaptation to changing needs and new challenges in health care. Competency- or outcome-based medical education defines the profile of graduates from our medical faculties. These profiles should be in alignment with postgraduate training, that builds on the foundation of medical knowledge, skills and attitudes that medical students acquire during their studies. Internationally, the physician’s roles derived from the CANMeds-Framework have set a standard also for undergraduate training e.g. in the Netherlands and in Switzerland. Since 2009, the German national competency-based catalogue of learning objectives ("Nationaler Kompetenz-basierter Lernzielkatalog Medizin - NKLM") is under development as a joint undertaking of the German Association of Medical Faculties ("Medizinischer Fakultäten-Tag - MFT") and the Association for Medical Education in the German-speaking community ("Gesellschaft für Medizinische Ausbildung - GMA"). It has also adopted the CANMeds-roles and has adapted them to the German context. The key element of the NKLM is its sound science orientation. The role of the scholar is composed of four competences focusing on life-long learning, teaching, critical appraisal of scientific knowledge and innovation. Furthermore, all knowledge, skills and attitudes underlying these roles from normal structure and function of the body to scientific, clinical and communication skills are defined. All key signs, symptoms and findings as a starting point for consulting a physician and disease related prevention, diagnostics, therapy and management of care are contained. Presumably, a revised version of the NKLM will be approved by the German medical faculties by mid 2015.

What will physicians need 10 to 15 years from now? Well, we should actually teach exactly in a way that meets those needs, as it takes 10 to 15 years until our 1st semester students will be expert physicians in the system. Some assumptions are, that physicians in 2030 more than today

1. will be flexible information managers,
2. will need to protect themselves against continuous availability,
3. will either be even more specialized or more integrative generalists to serve as pilots for patients route through the system,
4. will be resource managers in a competitive system of care providers,
5. will be constant teachers and learners at the same time,
6. will be more accountable for their actions,
(7) will be team leaders and team members in multiple health care contexts as well as in research and education,
(8) will use scientific reasoning and argumentation in conjunction with information technology,
(9) will be clinical decision makers and communicators as partners of patients, and
(10) will need to communicate errors and limitations of health care to patients and society.

This list is of course not complete. At any rate, medical education will mirror the respective society’s view on the needs of its patients. It seems key, that the patient remains in the center as health care should be for patients and not primarily against diseases.