

harm than good. GPs should consider whether prescribing antibiotics for a URTI is ethically justifiable, in view of guidelines, evidence, and ethics.

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DOI: 10.3399/bjgp11X583100

Minimal undergraduate teaching curriculum in Europe

Elizabeth Brown and colleagues have pointed out significant differences across the European Union in GP-training and in family medicine (FM) teaching.¹ GP-training and the choice of general practice as a profession depend, to a large extent, on the level of FM teaching at undergraduate level. Only if we teach FM at this stage, can we introduce all of them to this discipline as framed by the European Definition. Only if we introduce students for

a short clerkship in the practices, will we get new doctors who are really willing to train as GPs. Also, all doctors, whatever their final speciality, will understand the place of FM in the healthcare system.

As the EURACT Basic Medical Education Committee, we produced and presented research on FM undergraduate teaching in Europe,^{2,3} using a Delphi study to determine a minimal curriculum.

The length of the FM/general practice clerkships/undergraduate programmes range from 1 to 12 weeks in different countries, and among different universities in a single country. Inter-country and intra-country variations are seen not only in the length of the programme but also in its content. Since there is no uniform curriculum for FM/general practice across Europe, the aim of this study was to create and suggest one.

The Delphi method was used among the national representatives ($n = 40$) in the EURACT Council. A total of 25 responses were obtained on the first round (62.5% response rate). The 375 themes suggested were then reduced by the researchers to a list of 87. This list was sent again by email. On the second round, 27 responses were obtained (67.5% response rate). A final list was generated after ranking. The third round closed the final 15-item list. 'Final tuning' voting was performed during the council meeting to ensure maximal consensus.

This list could be used in the future for the development of a uniform undergraduate curriculum for FM/general practice across Europe, to promote its development in countries at a lower academic level in FM, and to achieve the reputed uniformity required for high levels of teaching for better free movement of future doctors across the labour market.

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Please contact the Journal office for the 15-item list at journal@rcgp.org.uk

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DOI: 10.3399/bjgp11X583029

The diagnostic value of symptoms for colorectal cancer in primary care

I was most impressed with the paper by Astin *et al* on the diagnostic value of symptoms for colorectal cancer in primary care.¹ This is such important research, as each day we see patients with gastrointestinal symptoms and I find myself always concerned about missing the bowel cancer (where the prognosis is excellent when found early). My comment to Astin *et al* is that their abstract is confusing. Change in bowel habit (with rectal bleeding?) has a positive likelihood ratio but the bottom line of the results says the positive likelihood ratio (PLR) is 1 or less for diarrhoea or constipation (change in bowel habit). I am not sure which 'advice to follow' and I wonder how many of my colleagues are fully conversant with likelihood ratios, and for the sake of good communication, perhaps these should be translated in to text. Otherwise, well done to their team.

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DOI: 10.3399/bjgp11X583119

Knowing the accuracy of clinical tests in practice is useful to any clinician hoping to take an evidence-based approach to their practice, and the work of Astin and colleagues¹ provides a useful summary on the performance of clinical tests used to diagnose colorectal cancer in primary care. However, I believe there are two shortcomings to their analysis.