in primary care.[5,6]

Dr Fitzpatrick insinuates that coordinated public health strategies involving health professionals and physical activity promotion have 'no proven value in relation to health'. We congratulate Fitzpatrick on promoting lifestyle promotion at his clinic, according to the NHS Information Centre, last year his own surgery achieved 100% incentivised payments from QOF for lifestyle promotion indicators. Brief interventions in primary care achieve similar concordance with physical activity to prescribed medication,[7,8] so lifestyle recommendations are in fact of very great value in relation to health with far wider collateral benefits.[9,10,11]

Physical activity promotion and lifestyle advice are included as the first treatment recommendation in 39 different sets of clinical guidelines in the UK because evidence supports that physical activity can be used to treat the same diseases that physical inactivity causes (and improve quality of life, mental health, productivity, and academic achievement).[12]

Medical ethics, medico-legal duties of care, and perhaps even moral responsibility also underpin the need for physical activity promotion, to the extent that General Medical Council *Good Medical Practice* obligations, state that 'You should encourage patients and the public to take an interest in their health and to take action to improve and maintain it. This may include advising patients on the effects of their life choices on their health and well-being …'.[13]

As a start, some simple tips assisting doctors with physical activity promotion in primary care was recently published in the *BMJ*.[14]

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Time for a national undergraduate curriculum for primary care

Blythe and Hancock pose an interesting question, but their article does not highlight three important issues.[1] First, that an undergraduate curriculum results in a generic 'product', whose nascent knowledge and competency must relate to patient care regardless of their subsequent specialisation. Second, that these competencies will be attained in different ways in different settings, and often are and should be practised in more than one undergraduate setting or speciality, both prescribing and consultation skills are exemplars. Third, the fact that a specific speciality does or does not lead on a specific component may not mean that the graduate fails to achieve that competency. So, let's pretend that medical school (a) makes prescribing tasks a core learning activity of its final year GP placement, but medical school (b) signs off this competency at the end of year 4 in the medicine for the elderly placement, and uses its final year GP placement to focus on the applied skills of acute diagnosis of undifferentiated problems. From the primary care curriculum in each school this will look different, but both sets of graduates should be able to succeed in relevant work-based and 'objective structured clinical examination' type assessments.

The idea in this article, therefore, needs further refinement to ensure it will provide useful information that will act as a driver for relevant change, as trying to map entry competencies for MRCGP onto GP departmental teaching alone would not reflect such legitimate variation. A national comparative mapping of current use of primary care placements,[2] and the learning objectives they prioritise, might well be more informative, particularly because there are clear differences in long-term career impacts that may relate to the nature and status of GP-teachers in different UK medical schools.[3] Links between GP teaching leads at different medical schools are actually already established in the Society for Academic Primary Care's 'Heads of Teaching' network, and the Royal College of General Practitioners is, and will remain, a champion of exposing medical students and postgraduates to our discipline. Giving

students the building blocks for MRCGP is only part of what we should seek to achieve, we need to show that all graduates leave medical school having learned to respect and aspire to the value of good generalist medical practice for patients, and seen its potential as an inspiring career choice.

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Andrew Blythe and Julian Hancock consider that the attraction and challenge of a career in general practice and family medicine is its diversity.[1] I would underline its specificity. Core competences for a GP are not ill defined, as might have been expressed by John Wayne 'a GP's got to do what a GP's got to do.' Since 2002, we had the European definition of general practice/family medicine by WONCA/EURACT, with 11 fields of specific action, and six core competencies (primary care management, specific problem solving skills, person-centred approach, comprehensive approach, community orientation, and holistic approach), that define the role of family medicine and the family doctor in society.

Of course, GP-trainers need clear objectives to ensure they deliver high quality education, and specialty trainees require clarity about what they should learn. But here we have since 2005, the EURACT Educational Agenda, defining in-depth what to teach and how, what to learn and how, according to the 11 fields and the six core competences in the European definition.

Every country should build on the success of its postgraduate curriculum by creating a national undergraduate curriculum for primary care. Many GP trainees have spent very little or no time in primary care since they were at medical school. All future doctors will be in contact in some way with primary care and should study primary care as a core part of their undergraduate curriculum.

There are significant differences across the European Union in GP training and in family medicine (FM) teaching. GP training and the choice of general practice as a career probably depends, to a large extent, on the level of FM teaching at the undergraduate level. Only if we introduce students for a short clerkship in the practices will we get new doctors really willing to train as a GP. Also, all doctors, whatever their final speciality, will then understand the place of FM in the healthcare system.

The EURACT Basic Medical Education Committee, has carried out a research study[2,3] on FM undergraduate teaching in Europe, using a Delphi study to determine a minimal curriculum. The length of the FM clerkships/undergraduate programmes range from 1–12 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 across Europe (and also nationally, the aim of this study was to create, or at least, suggest one.

The resulting document could be used in the future for the development of a uniform undergraduate curriculum for FM across Europe to promote its development in countries at a lower academic level in FM and to achieve the uniformity required for high levels of teaching and better free international movement of future doctors in the labour market.[4] Also, a nationally-agreed curriculum will facilitate the exchange of good practice between schools sharing teaching resources and examination questions and would strengthen the core curriculum itself and get medical students prepared.

According to David Bird,[5] the Foundation Programme is an excellent setting for improving communication skills within the doctor-patient consultation. Many patients choose to see a trainee rather than the regular GP because trainees can spend more time on each consultation and thus feel that their concerns can be expressed and addressed more thoroughly. A Foundation Programme so increasing patient satisfaction and also maintaining safe patient care should possibly be developed in many European countries.

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Trainees and palliative care

The tips offered to GP trainees is well balanced but with one significant omission.[1] No mention is made of the empowerment for the patient of an advanced directive (AD). GP trainees would do well to enquire if one is in place early on in the relationship so that the patient's wishes will be respected. AD's are part of the *Gold Standards Framework* checklist for palliative care but their use is still far from widespread.

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