Letters

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A response to RCGP Chair's 'Just Saying' on refugees to the UK being deported to Rwanda

'The only thing necessary for the triumph of evil is for good men [*sic*] *to do nothing'* are the words of philosopher Edmund Burke. Martin Marshall, RCGP Chair, chose these words to start his recent blog, 'Just Saying', calling out the British government on its plan to dispense with asylum seekers by deporting them to Rwanda.[1]

As GPs and hospital doctors we have been advocating on our migrant patients' behalf since the early days of the hostile environment in 2015, when the inhumane and unethical NHS charging regulations came into place.

However, we have rarely witnessed our NHS leaders speaking out against these issues.

Some humanitarian causes become collectively sanctioned, like the well-founded and applaudable response of the British public and individuals to the Ukrainian plight. Those supporting these just causes are no less admirable for their compassion and solidarity in action. Notwithstanding, there are those issues that we all feel in our heart of hearts are simply wrong, but we look around and see others, especially those we consider authorities, the know-betters, being silent. Seeing this, instead of calling this out, we choose to doubt our own moral intuition. Yet, those very moral wrongs that are less popular and ordered by authorities are those in need of bold leaders who are guided by their ethics rather than the seemingly 'proper' wrongs.

We (as NHS staff) know, as Martin Marshall knows 'viscerally', that the way we have allowed the government to tell us to turn a blind eye to the immense sufferings of those of our patients who are labelled 'illegal' is an utter violation of our professional ethics as well as our humanity.

We think Professor Marshall is mistaken in thinking that this is a 'complex' issue. It is not. Claims of 'complexity' are a reliable tactic to silence 'good people'. Over the past 8 years, we have seen UK Home Office policies increasingly impact the health of our patients, through data sharing, charging, quasi-detention, and now processing overseas. The Nationality and Borders Bill is the next in a long line of policies that callously and knowingly harm the health of an already vulnerable population.

It is time we spoke out. We must now rely on the courts, and legal challenges mounted against a government that seems to have lost any moral compass. We are not going to remain bystanders any more. We are not powerless, we are not voiceless, and our 'doing nothing' is inexcusable and a shameful legacy to our profession.

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Shaking chills may be better than rigors for sepsis prediction

I read the article by Loots FJ *et al* with great interest, and strongly appreciate the importance of the study.[1] The authors selected rigors (yes/no) as one of the candidate clinical predictors. The item of rigors was excluded in the simplified model because univariable and multivariable regression analyses showed no significant relationship between rigors and the diagnosis of sepsis.

The authors judged whether a patient developed rigors or not in a dichotomous manner. However, the degree of chills is important in predicting bacteraemia. For example, shaking chills showed a specificity of 90.3% and a positive likelihood ratio (PLR) of 4.65 for bacteraemia, while mild chills showed a specificity of 51.6% and PLR of 1.81 (see Tokuda *et al*).[2] Considering a higher specificity, shaking chills may be a more desirable candidate than rigors only.

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2. Tokuda Y, Miyasato H, Stein GH, Kishaba T. The degree of chills for risk of bacteremia in acute febrile illness. *Am J Med* 2005; **118(12):** 1417. DOI: 10.1016/j.amjmed.2005.06.043.

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Author response

We thank Junki Mizumoto for the interest in our study. We acknowledge that the study of Tokuda *et al* used a more detailed

description of the severity of chills.[1] The association between shivering and bacteraemia is proven more convincingly by showing that the relative risk increased in more severe categories of chills. However, our data showed no relation between rigors and the outcome sepsis. Rigors corresponds with shaking chills and it is very unlikely that we would have found an association, if we had used the same categorisation used in the study of Tokuda *et al*. Also, it is important to note that bacteraemia and sepsis are not the same. Shaking chills or rigors might be useful for the decision to prescribe antibiotics, but our study results do not show evidence of added value in the decision to refer a patient to the hospital for (possible) sepsis.

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Parity at last: a new funding model for undergraduate primary care education in England

It is indeed good news that undergraduate general practice attachments are at last to be funded at the same level as teaching in hospitals. But Rosenthal *et al*'s[1] history of the journey from the publication of the 1976 *Resource Allocation Working Party Report*[2] omits significant detail.

In fact, negotiations were set in motion in December 1981 by John Walker (in England) and John Howie (in Scotland) aiming to achieve a Service Increment for Teaching (SIFT) equivalent payment for teaching in general practice. These were protracted, meeting much resistance, but in October 1987, after many early legal difficulties had been resolved, Junior Health Minister Edwina Currie agreed, in a Parliamentary Adjournment Debate, to make financial support available to support undergraduate teaching attachments for the first time. This promise was eventually realised as part of the 1990 'New GP Contract', the payments being indeed set at 12.50 GBP per GP half-day session.

At the time we were delighted to be able to reimburse our service GP colleagues for teaching work that had previously been almost entirely voluntary, and general practice undergraduate teaching expanded. But until now equivalence of hospital and GP funding has never been achieved. Rosenthal's warning about future vigilance to maintain the hard-won new parity must be heeded.

July 2022 marks the 50th anniversary of the first Scientific Meeting of what developed into the Association of University Teachers of General Practice, since 2000 the Society for Academic Primary Care. To ensure that the history of the evolution of general practice as a university discipline is on record, we are preparing an 'archive', shortly to be lodged with Royal College of General Practitioners (RCGP) Archivist Heather Heath. This will include a paper record of the full story of the early SIFT negotiations complete with extensive excerpts from Hansard, parliamentary records, and correspondence with a succession of Chief Medical Officers and officials at the English and Scottish Departments of Health.[3]

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Author response

Thank you so much for filling this gap in the tortuous history of undergraduate general practice funding. We are all indebted to you, and your colleagues at the time, for setting these wheels in motion. We very much look forward to seeing your RCGP archive on the evolution of general practice as a university discipline.

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NICE guidelines traffic light system in children in general practice

The authors should be complemented on a fantastic analysis, challenging National Institute for Health and Care Excellence (NICE) guidelines appropriately. The problem with any assessment is that it is dynamic, patients can become ill, and it is a time-related assessment. My experience is that in children you need a face-to-face assessment with good safety-netting structures. The irreplaceable 'gut' feeling is only acquired by very many clinical encounters, so GPs recognise what they are looking for, because they then ask the right questions in the right way. Parental concerns can be misleading. I have seen several parents, who had good parenting skills, suddenly switching off their normal thinking process when a child was very seriously ill. This is an assessment that could be made pretty much on the spot.

Reduction of working hours, the European Working Time Directive, and lack of clinical exposure at all levels, including taking clinical responsibilities early in this training process, cannot be replaced by any guideline. The pendulum has to be swung backwards.