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.