

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*'s¹ 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.

General practice is a beautiful job; however, it is never, ever going to be easy. It takes an extraordinary amount of effort to get it right. Training must be lengthened and intensified.

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Impact of COVID-19 on primary care contacts with children and young people in England — context please

Foley *et al*'s article¹ lacks the context of these figures with no mention of the direction that was suggested to primary care by NHS England and indeed the government.^{2,3}

The authors also fail to mention that this was also during times when no vaccination was available and some high-risk colleagues could not see patients physically. Do not forget that the lack of PPE and deaths of healthcare staff as a result of the pandemic were ever present.

I am disappointed that this article only shows figures with absolutely no context at all and meant to further chastise primary care.

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Author response

Our article does not 'chastise' primary care.¹ We fully understand the pressures that NHS primary care is currently under.² We have included the appropriate context for our figures showing falls in GP contacts with children. Our article begins by mentioning NHS England directives to protect patients and healthcare workers from COVID-19, describing that the NHS recommended remote triaging before any face-to-face contact to reduce infection risk. We also state that the public were advised to stay at home to limit transmission of COVID-19 to reduce pressures on the NHS, and that GPs were asked to prioritise consultations for urgent and serious conditions, and suspend routine appointments for planned or preventive care. Throughout our discussion, we provide suitable context for our figures by explaining that at the start of the COVID-19 pandemic remote consultations provided practical solutions for GP appointments for those shielding or self-isolating.

Hence, our message is that GPs were able to manage children and young people safely during the most challenging period of this pandemic. This was a time when there were shortages in protective equipment, and when the risk to healthcare workers was highest. All those working in primary care should be proud of how they rose to meet these challenges at the start of the pandemic.³

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Corrections

Mona Johnson, Mary Doherty, and Sebastian CK Shaw, Overcoming barriers to autistic health care: towards autism-friendly practices. *Br J Gen Pract* 2022; DOI: <https://doi.org/10.3399/bjgp22X719513>. An editorial error resulted in inaccurate terminology: 'people with autism', 'patients with autism', and 'adults with autism' should read as 'autistic people', 'autistic patients', and 'autistic adults'. We apologise for this error. The online version has been corrected.

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Joe Rosenthal, Richard Darnton and Alex Harding, Parity at last: a new funding model for undergraduate primary care education in England. *Br J Gen Pract* 2022; DOI: <https://doi.org/10.3399/bjgp22X719525>. This article is Open Access: CC BY 4.0 licence (<http://creativecommons.org/licenses/by/4.0/>). This statement has been added to the online version.

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