Letters

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Editor's choice

QOF: is it worthwhile?

Des Spence, in his July article in the *BJGP*,[1] adds to the growing chorus suggesting QOF has done little if anything in terms of health improvement, but let's just hold fire before we get criticised again for our work and income. Life expectancy is increasing, premature mortality is decreasing, but our disease 'counting' has also increased. Yes QOF, especially in the last few years, has had targets that make no scientific sense and is contrary to the idea of shared patient care and often logic and plain common sense. But there are practices where for a variety of reasons, care is suboptimal and the patients registered have morbidity and mortality that are increased compared with their locality. If these can be identified through QOF and help given, nobody is the loser.

John Sharvill,
GP, Balmoral Surgery, Kent.
E-mail: john.sharvill@nhs.net

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Detachment and empathy

I thought Luke Austen's article[1] was very impressive, not least because its author is still an undergraduate; that is, still at the stage of having his head crammed with facts. It prompted recollection of TS Eliot's lines from 'The Rock':

> *'Where is the wisdom we have lost in knowledge?*
> *Where is the knowledge we have lost in information?'*[2]

Sooner or later — and it's often while at medical school — all doctors experience situations that are unforgettably shocking or traumatic. Many of us respond self-protectively by detaching our human responses in order to cope. It's as if a switch is thrown, disconnecting our clinical skills from our emotional intelligence. (In my recent book *The Inner Physician* I call it 'Crichton's switch'.)[3] And in some of us that switch never gets reversed.

Austen suggests there needs to be a balance between empathy and detachment. But I think it's a bit more complicated than that. There are some clinical situations where hard-nosed clinical skill is all that is required, and others where the very best we can offer is our ability to understand and to empathise. The novelist EM Forster I think gets closer when (in a different context) he writes, *'The businessman who assumes that this life is everything, and the mystic who asserts that it is nothing, fail to hit the truth. No; truth, being alive, was not halfway between anything. It was only to be found by continuous excursions into either realm.'*[4]

In other words, Crichton's switch is a toggle switch, with no midway position; it alternates between being on and off. The professional skill, if there is one, is to be in control of it, able to engage or disengage our empathy according to clinical circumstances.

Roger Neighbour,
Past President, RCGP.
E-mail: rogerneighbour@gmail.com

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A change in the NICE guidelines on antibiotic prophylaxis for dental procedures

We would like to add an important footnote to the article on dental problems by Renton and Wilson in the August *BJGP*.[1] You'd be forgiven for missing it, because it was announced without fanfare, but the National Institute for Health and Care Excellence (NICE) has added the word 'routinely'[2] to Recommendation 1.1.3: *'Antibiotic prophylaxis against infective endocarditis is not recommended* routinely *for people undergoing dental procedures'* [authors' emphasis].

This change occurred after a patient with a replacement aortic valve died from infective endocarditis (IE) developing after unprotected descaling, and followed approaches to NICE by the patient's widow and her MP. Their case included: evidence that antibiotic prophylaxis is effective in people at high risk of IE having high-risk dental procedures (Box 1),[3] the observation that the incidence of IE in the UK has accelerated above the global background rise since the original 2008 NICE guidance;[4] and a change in the law on consent.[5]

Box 1. Summary of guidance

- Patients at high risk: replacement heart valves or prior endocarditis.
- Patients at moderate risk: native valve disease.
- High-risk dental procedure: extraction, deep descaling.
- Antibiotic prophylaxis: indicated for people at high risk having high-risk dental procedures. Record details of consent process in the dental notes. Use amoxicillin 3 g or clindamycin 600 mg orally 1 hour before.
- Other advice: dental surveillance 6-monthly (high-risk patients) or annually (medium-risk patients); avoid tattoos and intravenous drug use.

Warning: consider infective endocarditis with unresolving fever or night sweats, especially with systemic symptoms. Consider blood cultures before starting an antibiotic course.

It is now necessary for dentists to explain to their patients the differences between NICE and other guidelines if it is likely that they would have a special interest, for example, patients with replacement heart valves or prior IE.[6] Their GP or cardiologist may consider advising the patient and their dentist on the level of risk by letter. The dentist should then allow the patient to make up their own mind whether or not to have antibiotic prophylaxis. The General Medical or Dental Councils' standards and the advice of the medical or dental defence organisations highlight the need for this discussion (and the patient's decision) to be recorded in the clinical records.

Prophylaxis should be with amoxicillin 3 g by mouth 1 hour before the procedure or, for patients with penicillin hypersensitivity, using clindamycin 600 mg. Other guidance is given in Box 1. It is also important to educate patients at risk in recognising the possibility of IE, typically if there are unresolving night sweats, especially with constitutional symptoms like weight loss. The British Heart Foundation produces warning cards that can be given to patients: https://www.bhf.org.uk/publications/heart-conditions/m26a-endocarditis-card.

The subtle change makes NICE guidance less dogmatic and allows clinicians to use their clinical judgement, follow well-accepted international guidelines,[7] and provide the care their patients want.

Martin H Thornhill,

Professor of Translational Research in Dentistry, the School of Clinical Dentistry, University of Sheffield, Adjunct Professor of Oral Medicine, Department of Oral Medicine, Carolinas Medical Center, Charlotte, North Carolina, US.
E-mail: m.thornhill@sheffield.ac.uk

John B Chambers,

Consultant Cardiologist and Professor of Clinical Cardiology, Guy's and St Thomas' Hospitals, London.

Mark Dayer,

Consultant Cardiologist, Taunton and Somerset NHS Trust.

David Shanson,

Honorary Consultant Microbiologist, Great Ormond Street Hospital for Children, London.

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Resilience of primary healthcare professionals working in challenging environments

The article by Matheson and colleagues in the July *BJGP* refers to the development of resilience through experience, learning from others, and training.[1] I would be interested to know whether a placement in mental health during training enables professional resilience later on. I write this as a child and adolescent psychiatrist, and former Director of Medical Education of a large mental health NHS trust in England where I successfully implemented posts in youth mental health teams, CAMHS, and eating disorders services. The management of uncertainty and anxiety within a multidisciplinary context and the opportunity to learn systemic skills in working with families received very positive feedback from GP trainees. Also, the opportunity to attend Balint groups for psychiatry trainees helped engender a positive and optimistic outlook on the work being done.

Stephen Mark Jones,

Consultant Child and Adolescent Psychiatrist and former Director of Medical Education, HEEoE Independent Sector.
E-mail: smjones@doctors.org.uk

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Clinical checklists, tick boxes, and other aides memoire in end-of-life care in out-of-hours general practice

Although the 2015 NICE guidelines *'supplement the individual clinical judgement that is needed to make decisions about the level of certainty of prognosis and how to manage any uncertainty'*,[1] the difficulties and uncertainties described by Dr Knights[2] still exist in out-of-hours (OOH) palliative care in the community or general practice setting. Guidance from pathways or protocols can provide a helpful framework for the home healthcare team, including the visiting OOH GP, who may well not know the patient. Insufficient care and treatment in the absence of clear protocols may, as Dr Knights points out, be a more likely outcome than inappropriate treatment in their presence. A typical GP consultation is undertaken to understand and agree with the patient or relatives what condition management and outcomes can be achieved. Not all boxes need ticking. Relevant ones need to be considered, managed, and reviewed, with a 'safety net' that takes into account the variability and uncertainties of health, conditions, and people. In his final section on the case for 'tick box' end-of-life care, Dr Knights makes his points well regarding such care in hospital, and the valuable practical assistance to all that accepted protocols or checklists can give. Their absence may