

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.

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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.

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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 Knights² 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

make it more difficult to implement NICE guidelines consistently. We feel that his concerns are at least equally applicable in OOH GP work.

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Empathy, compassion, and kindness

July's *BJGP* had articles on empathy, compassion, and kindness.¹⁻³ In the same month I received an invitation to apply to join the interview panel for prospective medical students. The invitation says that

these 17-year-olds are going to be assessed for their social awareness, caring ethos, and empathy. I wondered which of these unfortunates was going to be rejected for not feigning these attributes as convincingly as their competitors. And I wondered what sort of god-like creatures may exist among the pool of senior doctors who would be willing to dispense such judgements on the innocent. Perhaps none with any vestige of empathy, compassion, or kindness.

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From Balint to square bashing

Zigmond's article in the July *BJGP* is

brilliant.¹ It describes to us exactly how personal contact has been replaced by computers. Although I am retired, I resent this modern intrusion. I have heard anecdotally of patients saying 'he constantly looks at the computer screen' or 'she is typing on the keyboard, with her back turned from me, the patient. There is hardly any eye to eye contact!' This continues after the patient has walked out of the surgery because the prescription has already been sent to the pharmacist electronically. This IT innovation has created a vacuum in the doctor-patient relationship. I had the privilege of attending Balint Seminars at the Tavistock Clinic, and I strongly believe in Balint's doctrine of that relationship. Zigmond rightly says in his article, '... we have replaced that human heart with a mechanical one that can count but cannot value'. It seems gone are the days of the adage 'Listen to the patient. They are giving you the diagnosis.' Instead of listening, talking, and looking at the patient we might as well click on Google to do the job.

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