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.

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REFERENCE

1. Spence D. QOF's post-mortem. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X685909. http://bjgp.org/content/66/648/371.

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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.

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REFERENCES

1. Austen L. Increasing emotional support for healthcare workers can rebalance clinical detachment and empathy. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X685957. http://bjgp.org/content/66/648/376.
2. Eliot TS. Choruses from The Rock. In: *The poems of T. S. Eliot volume I: collected and uncollected poems.* London: Faber & Faber, 2015.
3. Neighbour R. *The inner physician.* London: RCGP, 2016.
4. Forster EM. *Howards End.* London: Penguin, 2000.

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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.