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The day we met Julian Tudor Hart

One sunny April day in 2014 we knocked on the cottage door. We had arranged to see Julian Tudor Hart but his wife Mary told us he was not well. *'But wait a minute'*, she said.

'Yes', it was OK to come in. Julian was in pain from sciatica and rather fed up. However, he roused himself and within moments the conversation was flowing. As it then did over lunch and all afternoon.

He was then 87 and had spent most of his working life at Glyncoed Health Centre, in a former mining valley in South Wales. His left-wing lay deep and he stood unsuccessfully for parliament three times as a Communist Party candidate. Although personally charming, considerate, and hospitable, he still was fiercely opposed to politicians whom he thought were betraying ordinary people.

We ranged over his considerable research, the 'Inverse Care Law' being the prime example. By his life he showed that it was possible to combine daily practice with substantial academic work. In 2006, he was awarded the inaugural Discovery Prize by the RCGP as *'a general practitioner who has captured the imagination of generations of GPs with his groundbreaking research'*. He was respected by those who held very different views from his own, and in turn freely admitted learning from those who opposed him.

Retirement for Julian was clearly not inactivity and his passion never faltered as we talked. Inevitably the time to leave drew near and we admired the view over the Gower from his window. We broached the question of why the glorious creation we see can be evidence for a Divine Creator. And Julian, deeply convicted socialist that he was, surprised us by his answer. *'I am closer than you think.'*

Julian Tudor Hart had a vast influence on others personally, medically, politically, and academically. He showed us how fruitful a dedicated life can be, even a mere practising GP.

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Sadly John Holden died soon after writing this letter. His Appreciation can be found next to Julian Tudor Hart's on pages 432–433.

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Clinical reflection: part of being a good doctor and a necessary ingredient for high-quality patient care, and lifelong learning

I very much appreciate the article by Harris and colleagues flagging up the topic of reflection in NHS appraisal and the negative experience and feedback on reflective writing.¹ Reflective practice is an essential activity for healthcare professionals and should be an integral part of all aspects of healthcare delivery, as it aids the development of professionalism by facilitating lifelong learning and can reduce diagnostic errors.² Reflective writing can help to process emotions, improve mood, prevent burnout, and improve the patient's care.³ Clinical reflection is not developed spontaneously and therefore is an essential part of the curriculum development.⁴

Unfortunately, despite being part of the undergraduate education, some students perceive reflective writing as irrelevant or even a nuisance or a waste of time. Reflection and reflective writing are clinical-relevant skills, and their practice can help with becoming a better physician. Clinical reflection shouldn't merely be reduced to a tick-box exercise, but progress to a powerful tool, which can be individualised by the user to connect up-to-date learning and teaching methods.⁵ Further studies are needed in order to evaluate the effect of different educational strategies and supportive tools to promote its development and prevent reflection fatigue.⁶

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Management of exertional heat stroke

I read with interest the article by Wallace and Steel regarding the management of exertional heat stroke from primary care physicians.¹ Without question, improper management and care of an exertional heat stroke (EHS) patient can lead to increased risk of morbidity and mortality, thus necessitating the adoption and implementation of current standards of care for the recognition and management of EHS.^{2–4}

With a focus on the primary care physician in this article, the authors discuss the onsite treatment of EHS (for example, during a mass participation event such as a road race) and subsequent care following the event. Within the section on EHS treatment, there are a few concerns that must be addressed. First, to reduce the risk of long-term morbidity or mortality related to EHS, the primary goal for EHS treatment is to reduce core body temperature below the critical threshold of cell damage (>40.83°C) within 30 minutes

of collapse.²⁻⁴ Minimising the time above the critical threshold for cell damage decreases the extent of tissue and organ damage within the body. Demartini and colleagues showed that, when body temperature was reduced below the critical threshold in 274 individuals who had succumbed to EHS, there was 100% survival without any known sequelae.⁵ Second, the mode of body cooling should be such that the cooling rate is optimal (>0.15°C/min) for EHS treatment.⁶ Alternative options such as tarp-assisted cooling have been shown to be just as effective as cold-water immersion and can be implemented with ease.^{7,8}

To optimise the treatment and care of individuals suffering EHS, it is essential that patient care take an interdisciplinary approach. Coordinating care between onsite medical providers (for example, athletic trainers, other sports medicine professionals), emergency medical services, and primary care physicians allows for a seamless transition of care between medical providers to optimise patient outcomes.

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Minimising iatrogenic nerve injury in primary care

Wallis and colleagues did not find any cases of nerve injury relating to contraceptive implant insertion/removal in the New Zealand claims dataset. However, such injuries were first reported more than 20 years ago with the 6-rod Norplant and frequently lead to litigation. I have seen 11 such cases in my medicolegal practice. The site for such injuries is the sulcus between biceps and triceps in the upper arm, 8–10 cm above the medial epicondyle. Three nerves run in a neurovascular bundle just below the fascia: the median, ulnar, and medial cutaneous nerve of the forearm. All three have been injured at the time subdermal implant procedures are performed.²⁻⁶ These injuries continue to happen, despite the recommended site for insertion having been moved away from the sulcus in 2008. The injuries generally occur when blind instrumentation is performed during attempts to remove implants that are situated deeply or are tethered. Some women have suffered permanent neurological deficit, despite undergoing neurolysis procedures. In my view, routine removals should only be carried out by the 'pop-out' technique (for a nice demonstration of this, see this videoclip: bjgplife.com/popout). Attempts at removal should be abandoned if not straightforward or if the woman complains of sensory symptoms.

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Corrections

Research by Shephard EA and Hamilton WT, Selection of men for investigation of possible testicular cancer in primary care: a large case-control study using electronic patient records. *Br J Gen Pract* 2018; DOI: <https://doi.org/10.3399/bjgp18X697949> showed an inaccuracy in the print version. The printed version states 'Testicular swelling alone has a PPV for cancer just below the 3% threshold, but when combined with testicular, groin or abdominal pain, particularly in men aged >50 years, the likelihood of cancer is considerably greater.' The corrected version should read 'A testicular lump alone has a PPV for cancer just below the 3% threshold, but when combined with testicular swelling, pain or abdominal pain in men <50 years, the likelihood of cancer is considerably greater.' This appears in the grey box at top of print abridged version only. The online version is correct.

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Research by the DAMASK Trial Team, Cost-effectiveness of magnetic resonance imaging of the knee for patients presenting in primary care. *Br J Gen Pract* 2008; DOI: <https://doi.org/10.3399/bjgp08X342660> showed mean QALYs over 24 months as difference = 0.050 and 95% CI = 0.025 to 0.118 in the Abstract and Table 4. The lower CI is missing a minus, and it should read -0.025 to 0.118, around a difference of 0.050. The online version has been corrected.

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In the study by Davies J *et al*, Long-term benzodiazepine and Z-drugs use in the UK: a survey of general practice. *Br J Gen Pract* 2018; DOI: <https://doi.org/10.3399/bjgp17X691865>, the data for the general population of NHS patients in 2014 were for England only, rather than the UK as a whole. The correct article title is 'Long-term benzodiazepine and Z-drugs use in England: a survey of general practice', and there are changes throughout the article to reflect this. The online version has been corrected.

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