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Editor's choice

Bad medicine: resilience

I read Dr Spence's polemic against resilience support and training with a mixture of sadness and disappointment.¹ I am sad that he had a poor experience of training. It is terrible that he felt no support or worthwhile mentoring from the old style 'firms' who trained him. This is very different from the experience I had, in the same country and era, which was enhanced by many excellent role models and at its best created a real feeling of belonging.

I am disappointed at the offhand dismissal of a whole area of psychological theory and a simplistic conclusion that ignores the complexities of the interactions between life, work, and the individual.

Clearly improvements in the workload, working environment, and organisational culture of health care are vital in protecting staff from stress. Having said that, bad things will still happen in the quietest, cleanest, and best-run health centres and hospitals. Patients die unexpectedly and make complaints no matter how good your job, home life, and upbringing. It is vital that we make efforts to allow doctors to handle these events, which are an unavoidable part and parcel of our lives.

Resilience isn't hardness, stiff upper lips, cynicism, or emotional blunting. It's talking, openness, maturity, and professionalism. Good medicine.

Gregory C Jones,
Consultant/Associate Postgraduate
Dean, NHS Education Scotland.
E-mail: g.jones3@nhs.net

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The value of clinical examination

The article 'Bad medicine: clinical examination' might have made me chuckle at the imaginative use of Harry Potter references but it did not persuade me to change my clinical practice.¹ The author seems to equate disdain for the perceived hierarchical teaching and comment from medical schools and royal colleges as proof that clinical examination has no relevance.

He suggests that we 'embrace technology' and cites how CT and MRI have blown away the pomposity of consultants; both these things may have merit but they do not mean that examination is without value. He is right that it is dangerous to rely on clinical examination. But a good clinician will take a full history and enhance that with appropriate examination; there is no absolute reliance. As a GP, I don't have access to investigations during a consultation; examination helps to determine whether an illness can be managed in primary care or needs to be referred for further investigation or secondary care consultation and whether such referral should be routine or urgent.

He again highlights intimate examination such as pelvic examination (bimanual examination +/- visualisation of the cervix).² The evidence that this examination is of no benefit to asymptomatic women is clear, but to suggest that pelvic examination has no place in the management of symptomatic women is cause for concern. There has been little research conducted into the role of pelvic examination in primary care so evidence is limited, but what evidence there is supports the use of pelvic examination prior to referral.³ There is nothing illogical about using pelvic examination to determine if a patient's postcoital bleeding is caused by a cervical ectropion or polyp or a possible cervical cancer.

Pauline Williams,
GP/CSO Clinical Academic Training Fellow,
University of Aberdeen.
E-mail: pauline.williams@abdn.ac.uk

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Bad medicine: clinical examination

Des Spence questions the value of clinical examination and claims that '... the most common defence is that doctors need these "skills" to work in low-income countries'.¹ This is untrue. Practitioners, when making a clinical decision with patients, need to incorporate all the tools available to them, including the patient's background, a focused history, and a clinical examination. The thought processes of many junior hospital doctors are echoed by Dr Spence. As a result departments become saturated, tests beget tests, and decisions spiral ever upwards. One of the first lessons of a new GP registrar is to 'unlearn' this mindset.

A reassuring history and *negative* examination allow us to use time. Conversely, a worrying history especially with demonstration of hard physical signs guides us to the next stage. The skill then becomes 'when to do what'. Patients have a right to expect their GP to recognise serious illness: the 'rare but important' if you like. In adults the acute physicians now use a generic National Early Warning Score to spot such cases. Guess what? The parameters are clinical.² Please don't throw your stethoscopes and thermometers away yet. When the chips are down you may one day need them.

Michael Houghton,
GP, Leagram, Nr Preston, Lancashire.
E-mail: mike.houghton@nhs.net

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