able to adequately perform my job role, both caring for my patients and providing medical advice to the command team and supporting my unit on operations.

Yes, relying purely on clinical examination is dangerous, but so is relying on technology: it can break, can be unavailable, and is expensive! A doctor should have the knowledge and skills to formulate a differential diagnosis based on history and examination alone, and utilise focused investigations where possible to prove the diagnosis and/or direct the management of the case. Patients expect this and respect our abilities as doctors. In this increasing time of stretched resources, the 'dark art' of clinical examination, although not ideally sensitive or specific, at least is quick and cheap, and a key skill that all doctors should seek to perfect.

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Bad medicine: Spence and his spells

Des Spence has no doubt learned his craft the hard way.[1] If his intention is to make the business of diagnosis and treatment easier for his younger Muggles, he could do no better than direct his students to refer to *Primary Care Diagnostics* by Nick Summerton.[2] The answer to his spells is to be found in the library, not the clinical imaging department.

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The value of clinical examination: author response to Dr Pauline Williams

Thank you for your response.[1] Writing is sometimes about trying to engage the reader even if you have serious points to make! In fact I do not suggest that examination has no value, merely that this value is over-stated. Clinical examination has huge potential for false positive and false negative results, so as a diagnostic tool it has only limited value. I suggest that we teach students a cut-back version of examination and impress on them the limitations of clinical examinations. Much of what I was taught should be cast down.

Bimanual examinations miss more than one in three masses, even in hospital patients under general anaesthetic. The error rate is likely much higher in low-risk GP populations.[2] The clinical value of all bimanual examinations in any setting is highly questionable. Speculum examinations clearly do have value but not routinely, as was the practice in the past. For example, there is no indication to do a speculum examination when taking diagnostic swabs, which is still common practice. Also, a normal examination in a symptomatic patient does not exclude malignancy of the cervix or the uterus.

The research you quote is interesting, although it is retrospective observational data.[3] I agree that if patients are referred they should be examined (speculum and inspection), but there is no evidence that short delays by GPs adversely affect outcome. The delays in diagnosis are greatest in the hospital sector. The real issue is that patients need quick access to definitive diagnostics like ultrasound, and that current delays in accessing hospital care are unacceptable.

Clinical examination is an overvalued belief system that the profession is emotionally invested in. We need to challenge and rethink our beliefs.