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.

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Supporting help-seeking across the ages by reducing our use of stigmatising labels

Mitchell and colleagues[1] provide a helpful commentary bringing out many key issues regarding help-seeking for mental health support among young adults. I suggest most of their proposals are relevant to all ages; also that we need to tackle head on the problem in clinical practice of dichotomising at the individual level into those needing and not needing help according to whether a 'disorder' is present.

The evidence they provide that it is young adults who are less likely to gain support is limited.[2] In our study, recently accepted by the *BJGP*,[3] 20–24-year-olds are the age group most likely to be referred and to access psychological therapy. Estimated prevalence of common mental health problems (CMHPs) according to the Adult Psychiatric Morbidity Survey starts at 13.8% for 18–19-year-olds, rises to 15.3% for 20–24-year-olds, peaking in 45–49-year-olds (20.6%). In contrast, annual referral rates to IAPT psychological services, as a proportion of CMHPs, peak in 20–24-year-olds (23.0%) and then decrease gradually from this point until 65–69 (9.7%); 18–year-olds (8.4%) are much lower and comparable with those 70–74 years of age (6.0%).

Mitchell and colleagues discuss stigma and self-reliance, but in my view they do not go far enough in addressing the current 'best practice' of designating individuals as either having or not having a 'disorder'. This is a particular problem when considering the role of the GP, both in our roles at the interface between lay and medical worlds, and in promoting better mental wellbeing. We need a way of providing a range of support for stress and reduced function, which is more flexible: one that recognises specific problems such as irritability, low mood, social anxiety, and consequent problems such as study performance, arguments, avoidance, and substance use, without the need for a diagnostic label. In this way general practice can be an important part of the crucial public health challenge of preventing and alleviating mental distress and suffering, in ways helpfully suggested by Mitchell and colleagues, without having to always arbitrate between those who are 'disordered' or not.

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Dead unequal

As a GP with an interest in palliative care my eye was drawn to your January 2017 briefing entitled 'Dead unequal'.[1] Referring to Graham Watt's 'Deep End' work in Scotland, you highlighted the economic differences between rich and poor that contribute to differential morbidity and mortality.

Just as in life there are postcode inequalities, in death there are equally significant inequalities. As well as a postcode lottery, there is a diagnostic lottery. Much better to have cancer than a non-malignant condition. Support to help people with cancer at the end of life is better resources and is more accessible than other conditions.

Despite the Scottish End of Life Strategy 6 years ago highlighting this diagnostic iniquity as a key target, there is still so much to do. Indeed, the 2016 Scottish strategy again has this as the number one priority: to identify more people with non-malignant disease for end-of-life care. Charities, such as Marie Curie, have now doubled their non-malignant effort, but the differential is still great as care models are so cancer-centric. So, in the end, you would probably benefit more from the right diagnosis even more than the right postcode.

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Correction

In the article by Robson J *et al*. NHS Health Check comorbidity and management: an observational matched study in primary care. *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp16X688837, the Discussion section 'Comparison with existing literature', third paragraph, stated *'... a not unsurprising result because only 35% of those randomised to invitation actually attended'*. This should state *'... a not unsurprising result because only 52% of those randomised to intervention attended at baseline and only 35% completed the study at 5 years'*. The online version has been corrected.

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