

Get it looked at

A short book about putting off the doctor, the dentist and
the screening test, because not knowing feels safer

unbry · Free to read, yours to keep

<https://unbry.com/read/get-it-looked-at>

First edition

Written by AI with human guidance. It can
contain mistakes, which later editions correct.

Contents

1. Before you start
2. The mole in the mirror
3. Why not knowing feels safer
4. "While I don't know, I'm fine"
5. "It's probably nothing"
6. "If it's bad, I'd rather not know"
7. "I don't want to waste their time"
8. "I can't face the chair"
9. The fear that gets you there and the fear that stops you
10. What the putting off costs
11. The kit in the bathroom cabinet
12. "You can never get an appointment"
13. Making the call
14. The decision
15. Bad news, brush-offs and the opposite problem
16. The mole again
17. Notes

Before you start

This is a short book and you can read it in two or three sittings. It's about one habit. You notice something about your body, or a letter arrives inviting you for a test, or you realise it's been four years since you saw a dentist. You think, "I should get that looked at." Then you don't. Weeks go by, and then months. The thing stays at the back of your mind, and now and then, usually at night, it comes to the front.

I'm going to argue three things. The first is that putting it off makes sense from the inside. Not knowing feels safer than knowing, and the feeling is strong and common. Researchers have found it in every group they've studied. The second is that the safety is an illusion, because the appointment doesn't change what's there. Whatever the mole is, it has been that since March, whether or not anyone looks at it. Most things people put off turn out to be nothing, which means the usual reward for going is relief. For the few that turn out to be something, earlier is nearly always better. Putting it off doesn't help in either case. The third is practical. There's a simple rule and a way of making the phone call, and chapters 12 and 13 cover them.

This book is not medical advice. I'm not a doctor and I can't tell you what your symptom means. What I can do is help you get it in front of someone who can. Where I say anything about health, I've taken it from the NHS or from published research, and the notes at the back say which.

Three cautions.

If something is happening right now that might be an emergency, don't book an appointment and don't finish this book. The NHS says to call 999 for sudden chest pain that doesn't go away, chest pain that spreads to your arm, neck, jaw, stomach or back, or chest pain with sweating, sickness, light-headedness or shortness of breath. If you're not sure how urgent something is, NHS 111 will tell you where to go.

If your trouble is the opposite of this book's subject, it isn't written for you. Some people worry about their health constantly, check their bodies often and go back to the doctor again and again for reassurance that doesn't last. The NHS calls that health anxiety. Chapter 14 says where to get help with it. Being told to get things looked at would make it worse.

And the services I describe are those in England. Screening ages, how you book and what things cost differ in Scotland, Wales, Northern Ireland and other countries.

Where I'm giving my own reasoning and not a finding, I'll say so.

The mole in the mirror

It's a Tuesday morning in September, and you're getting out of the shower.

In the mirror you catch sight of the mole on your left shoulder. You've had it for as long as you can remember. In March, drying yourself after a swim, you thought it looked different. It seemed a bit bigger, perhaps, and darker on one side than the other. You looked at it for a while, twisting to see. You thought, "I should get that looked at."

That was six months ago. You look at it again now. Is it bigger than in March? You can't tell. You've no photograph to compare. It might be exactly the same. You pull your shirt on, and as the collar goes over it the thought goes with it. You'll ring the surgery this week, when things calm down.

You've had that thought perhaps thirty times since March. Each time it has been followed quite quickly by another thought, and then by a small relief. It's probably nothing, since you've had it for ever. Ringing at eight means half an hour on hold. They're run off their feet, and you'd feel a fool going in with a mole. Work is mad this month. And under all of those is one that doesn't quite get put into words, which is "what if it isn't nothing?"

Then the shirt goes on and you get on with the day. Most days you don't think about it at all. But once every week or two it turns up uninvited. It comes when you see a headline, or when a colleague mentions a friend's diagnosis, or at ten past three in the morning

for no reason at all. At ten past three it doesn't feel like nothing. You lie there and promise yourself you'll ring in the morning. In the morning it's light, and it's probably nothing again.

You may not have a mole. Yours might be a lump, a cough that's gone on too long, blood where there shouldn't be any, a tooth that twinges with cold drinks, or a change in a habit of the body that you've been explaining away. It might not be a symptom at all. It might be an envelope. There's a bowel screening kit that's been in the bathroom cabinet since June. There's the letter about a smear test, the text from the surgery offering a health check, and the dentist you last saw when your youngest was in primary school.

I'll use a few terms. **The thing** is whatever you've noticed or been invited to, and haven't dealt with. **The putting off** is the habit of thinking "I should" and then not doing it. **The safe feeling** is the sense that while nobody has looked, nothing is wrong. **The call** is the act of booking, whether it's by phone, an online form or a walk to the reception desk.

The putting off has some regular features. This list is my own observation and not a research finding.

It begins with a true thought. "I should get that looked at" is correct. You've never disagreed with it.

A reason arrives within seconds, and it's always a respectable one. You're busy, or the surgery is, or it's probably nothing. The reason is never "I'm frightened".

A small relief follows. You've settled the matter for the moment and the day can go on.

And it comes back. The putting off doesn't get rid of the thought. The thought goes away for a week or so and then returns.

Before chapter 2, if you're willing, make a list. Write down everything of this kind that's outstanding. Include things you've noticed and haven't had checked, appointments you know are overdue, and invitations you haven't answered. Beside each, write roughly how long it's been. You don't have to do anything about the list yet. I'd guess there's more than one thing on it, and that the oldest has been there longer than you'd have said.

Why not knowing feels safer

If you've been putting something off for six months, you're in large company, and you're not being stupid. This chapter sets out why people do it, as fairly as I can, because the reasons are real.

Researchers have asked people directly. Jennifer Taber, Bryan Leyva and Alexander Persoskie analysed answers from 1,369 Americans in a national survey who were asked why they avoid medical care, even when they suspect they should go. More than half gave practical barriers like cost and time. In the American system cost is a large part of it. A third gave reasons the researchers grouped as unfavourable evaluations of seeking care. These included not liking or trusting doctors, bad past experiences, and what the researchers call affective concerns, which means fear, embarrassment and dread. And about one in eight said they didn't think they needed to go, often because they expected the problem to get better without treatment.

On the particular case of worrying symptoms, the fullest picture comes from a review by Lucy Smith, Catherine Pope and Johannes Botha. They brought together 32 studies from several countries, covering more than 775 patients and carers and at least twenty types of cancer. All of them asked people about the time between noticing something and seeing a doctor. The stories were strikingly alike across different cancers and countries. Two things kept appearing. One was the difficulty of recognising a symptom as serious. People explained things away as age, a pulled muscle, or something they'd eaten. The other was fear of the consultation itself, and that fear took two forms. There was fear of

embarrassment, either because the symptom seemed too trivial to bother a doctor with, or because it involved a private part of the body. And there was fear of cancer, meaning fear of pain, suffering and death.

From those studies and from ordinary experience, I'd list four reasons behind the putting off.

The first is fear of bad news. It's the deepest one and the least often said aloud. While nobody has looked at the mole, it's a mole. Once somebody looks, it might become something with a name. The appointment feels like the moment at which the bad thing could begin.

The second is fear of being a nuisance. The surgery is stretched, and everyone knows it. You picture the doctor's face as you roll up your sleeve to show a mole you've had for thirty years. You'd be taking an appointment from someone who's properly ill.

The third is fear of the procedure. This might be the dentist's drill, the smear test or the needle. It might be the examination of a part of you that you'd prefer nobody examined. None of that is pleasant, and for some people it's much worse than unpleasant.

The fourth is hassle. There's the phone queue at eight in the morning, the form on the website, the time off work, and finding a dentist who's taking patients at all. The obstacles are real, and chapter 11 doesn't pretend otherwise.

Under these lie needs that nobody should be ashamed of. You want to be well, and you'd rather not be frightened. You also want to be treated with respect, and you don't want to waste anyone's time,

your own included.

The question for the rest of the book is whether putting it off serves any of those needs. I'll take the four reasons in turn. I should say now where I'm heading, since this series doesn't keep secrets from the reader. In my view the putting off doesn't serve any of those needs. It gives you a small relief that lasts a week or so, and you pay for it with months of low dread and, now and then, with something far worse.

"While I don't know, I'm fine"

This is the belief at the centre of the habit, and it's hardly ever put into words, because it falls apart once you say it aloud. It goes like this. While nobody has examined the mole, I'm a healthy person with a mole. If I go, I might come out as a person with skin cancer. So the appointment is where the danger lies, and staying away from it keeps me safe.

But the appointment doesn't put anything into the mole. Whatever it is, it's that already. It was that in March when you first noticed, and it's been that every day since. If it's harmless, it's harmless now, and you've spent six months uneasy about a harmless thing. If it isn't, then it isn't harmless now either, and for six months it's had a free hand. The doctor's look changes nothing about the mole, only what you know about it. Knowing is the only route to reassurance if it's harmless, and the only route to treatment if it isn't.

Not checking the forecast doesn't keep the rain away. It only means you're out without a coat when it comes.

The feeling is persuasive all the same, and researchers have studied why. They call it information avoidance, and they've found that it follows a pattern. Alexander Persoskie, Rebecca Ferrer and William Klein looked at a nationally representative sample of American adults and asked who reported avoiding the doctor. Among people aged fifty and over, worry about cancer went with avoiding the doctor. But it did so only in people who also thought their chance of having cancer was high. The researchers' reading is

that worry sends people towards information when they expect it to reassure them. It sends them away from information when they expect it to confirm what they fear.

Consider what that means. The people most likely to stay away were the ones who were worried and thought something might be wrong. Those are the very people a doctor would most like to see. The avoidance grows with the suspicion. If you've put off the mole for six months and the dentist for four years, and you were quicker about the dentist, that fits. You stayed away longest from the thing you're most afraid of.

The safe feeling comes from being able to say, truthfully, "as far as I know, I'm fine". The words "as far as I know" are doing all the work in that sentence, and the putting off keeps them true by making sure you know as little as possible. But your body isn't affected by what you know. You can't keep the thing away by keeping the news away.

There's an honest objection, and I'll come to it properly in chapter 5. "Perhaps I'd really prefer not to know. If it's something terrible and nothing can be done, I'd rather have the extra months of peace." I understand that. For now I'll make two points. The first is that you aren't having months of peace. You're having months of ten past three in the morning. The second is that "nothing can be done" is almost never the situation with something caught early, and it becomes more likely the longer the thing is left.

So the choice isn't between a safe state, in which you don't know, and a risky act, which is finding out. The risk is whatever is or isn't in your shoulder, and finding out is the only thing you can do about

it.

"It's probably nothing"

Of all the reasons for not going, this is the one that's most often true. I'll start by agreeing with it.

It probably is nothing. Most moles are harmless. The NHS page on moles says most people have them and they're usually nothing to worry about, unless they change size, shape or colour. Its page on breast lumps says most breast lumps are harmless. It also says that when a GP refers someone to a breast clinic for tests, those tests usually show that the lump is not cancer. The same is true of most coughs, most aches and most changes that send people to a search engine at midnight. Bodies produce odd sensations and small changes all the time, and the great majority mean nothing.

So when the voice in your head says "it's probably nothing", the voice is right. Where it goes wrong is the conclusion it draws, which is "so I needn't go".

Think about what follows if it's probably nothing. It means that the most likely outcome of the appointment is good news. You'd walk in carrying a worry and walk out without it. The doctor looks at the mole for a minute, perhaps through a small magnifying instrument, and says it's the harmless sort. Six months of background unease would be gone in ten minutes. At present you're turning that down. You're carrying the worry when you could hand it to someone who can dispose of it.

I'd compare the two kinds of relief, because the habit runs on one and ignores the other. This is my own reasoning. When you think "it's probably nothing" and pull your shirt on, you get a small relief. It lasts until the next headline or the next ten past three. It has to be renewed every week or two, and each renewal is a little less convincing, because a part of you notices that you keep needing to say it. When a doctor tells you it's nothing, that relief is of a different grade. It comes from someone who knows and has looked, and it lasts.

There's a second branch, the unlikely one. Suppose it's something. Then "probably nothing" was wrong in your case, and every week you spent repeating it was a week lost. I'll deal with that in the next chapter.

Put the two branches side by side. If it's nothing, going gets you lasting relief, and not going gets you an occasional cheap relief and a continuing low dread. If it's something, going gets you an earlier start, and not going gets you a later one. I've tried to find the branch in which putting it off comes out ahead, and I can't.

One objection is worth answering. "If most things are nothing, then doctors' surgeries must be full of people with nothing wrong, and I don't want to add to that." Chapter 6 takes this up. The short answer is that the system is built on that basis. A GP can't find the few somethings without seeing the many nothings, because from outside they look the same. That's the reason you can't tell either. The NHS's own wording on breast lumps is direct about it. It says to always get a lump checked, and in the same breath that most are harmless.

So the NHS also thinks it's probably nothing, and its advice is still to get it checked.

"If it's bad, I'd rather not know"

This chapter is about the fear underneath the other reasons, and I'd like to treat it with respect. Fear of serious illness is one of the most reasonable fears a person can have. If part of you is staying away from the doctor because you're frightened of what you might hear, that part of you is trying to protect you.

My question is whether it succeeds.

The protection is supposed to work like this. If the news is bad, not hearing it keeps you out of the bad world a little longer. But that only holds if the bad world is equally bad whenever you enter it. For most serious conditions that isn't so. It matters a great deal whether the news arrives early or late.

Cancer Research UK publishes survival figures by the stage at which cancers are diagnosed, using NHS data for England from 2016 to 2020. For bowel cancer, about 91 per cent of people diagnosed at the earliest stage survive five years or more. For those diagnosed at the latest stage, the figure is about 11 per cent. For breast cancer in women, the figures are 98 per cent at the earliest stage and 27 per cent at the most advanced.

I should be careful about what those numbers do and don't show, because they're easy to misuse. They don't mean that any one person who waits six months moves from the first group to the last. Cancers differ in how fast they grow, and some are found late however prompt the person was. Part of the gap is an artefact of measurement, since a cancer found earlier has a head start on the

five-year clock. A large review of the evidence on delay, by Neal and colleagues, looked at 209 studies. It found them so varied in quality and method that firm overall conclusions weren't possible. What the reviewers could say was that for several cancers, including breast, bowel, head and neck, testicular and melanoma, more of the studies found that shorter times to diagnosis went with better outcomes. They concluded that it's reasonable to assume that faster diagnosis benefits patients, though the benefit varies from one cancer to another.

There's firmer evidence on delay once a cancer has been found. Timothy Hanna and colleagues pooled 34 studies covering more than 1.2 million patients, and looked at what happened when treatment was delayed. For surgery, each four-week delay was associated with a 6 to 8 per cent increase in the risk of death. That's about the wait for treatment after diagnosis, which isn't the same as the wait before seeing a doctor. But it suggests that time matters, at the scale of weeks.

I'm not going to press these figures further, and I won't repeat them. This isn't a book that works by frightening you. If fear were enough to get you to the doctor, you'd have gone in March. I give them once because they answer the question this chapter asked. "I'd rather not know" assumes that knowing later costs the same as knowing now, and it doesn't. If the news is bad, its size isn't fixed. How big it turns out to be depends partly on when you hear it, and you have some control over that.

There's a gentler point as well. Most of what people fear isn't cancer at all. The tooth that twinges needs a filling, which is a dull twenty minutes. If you leave it three more years it may need a root canal,

or to come out. High blood pressure that's found at a health check can be treated with a daily tablet. If it goes unfound, it can lead to a stroke. For the ordinary run of conditions the pattern is the same. When a problem is caught early, the treatment is usually smaller and the outlook better. The NHS page on dental check-ups puts it plainly. Leaving problems untreated could make them more difficult to treat in the future.

So the frightened part of you has it backwards. It treats the doctor as the source of the bad world. For most conditions, though, seeing the doctor early is how that world is kept small.

"I don't want to waste their time"

In Britain this reason has a special force. People know the health service is stretched. They've sat in full waiting rooms and heard the news about pressures on GPs. Taking an appointment for something that's probably nothing feels selfish. A decent person, the reasoning goes, leaves the slot for someone who's properly ill.

Researchers have looked closely at this worry. Susanne Cromme, Katriina Whitaker and colleagues interviewed 62 adults aged fifty and over in England. All of them had reported a symptom on a health survey that could be a warning sign of cancer, and still had it three months later. Many hadn't seen a doctor about it. The interviews asked why, and the worry about wasting the GP's time came up again and again.

The researchers found that the worry had particular sources. It was stronger when people could see the time pressure for themselves, in a rushed consultation or a packed surgery. It was stronger after an earlier visit where the GP had seemed dismissive. Many people felt a symptom only deserved a doctor's attention if it was persistent, getting worse or plainly dangerous. Surgery rules such as one problem per appointment made people feel they'd be breaking etiquette by raising anything extra.

They also found what eased the worry. A friendly relationship with a GP helped. Some people reasoned that they'd paid for the service through their taxes and were entitled to use it. Others took the view

that assessing symptoms is what a GP is for, and that deciding whether something is trivial is the doctor's job and not the patient's.

I think that last view is the right one, and I'd put it more strongly. This is my own reasoning. Nobody can tell a harmless mole from a harmful one by looking in the bathroom mirror, and that includes you. The whole value of a doctor lies in being able to tell. So "I don't want to waste their time with something trivial" contains a hidden claim, which is that you've already worked out that it's trivial. You haven't. If you had, you wouldn't be thinking about it at ten past three in the morning. Sorting the trivial from the serious is the doctor's work, and a patient who turns up with something that proves trivial has given the doctor that work to do. It's the most common kind of consultation there is, and nothing about it is out of the ordinary.

From the doctor's side, the expensive patient is the one who brings the mole after two years when it has become something that needs surgery and months of treatment. The one who brings it early and turns out to be fine costs far less. If the aim is to save the health service trouble, going early is how you do it.

There are also lighter ways in, which exist so that a GP appointment needn't be the first step for everything.

A pharmacist can look at a good many minor things and tell you whether you need a doctor. You don't need an appointment for that.

NHS 111, by phone or online, will ask you a set of questions and tell you what level of care you need. The NHS's own page on breast lumps suggests it for people who are worried about symptoms.

Many surgeries now have an online form where you can describe the problem in writing. Someone at the surgery reads it and decides whether you need to be seen, and how soon. For people who dread taking up a slot, that's ideal. The surgery makes the decision about whether you're worth an appointment, which is the very decision you didn't trust yourself to make.

If embarrassment is part of it, because the thing is somewhere private or to do with a bodily function, I can only give you my view. Doctors and nurses examine such things many times a week. What feels mortifying to you is routine to them. The review in chapter 2 found that embarrassment about a sensitive part of the body was one of the two big reasons people delayed over symptoms that turned out to be cancer. It's a common obstacle and a serious one, and the way through it is usually one awkward sentence. "I've got a problem that's a bit embarrassing to talk about." Clinicians hear that sentence often, and they know how to make the next minute easy for you.

"I can't face the chair"

For some things the fear is less about the news than about the experience. There's the dentist's chair and the sound of the drill. There's the speculum, the needle, or the scanner that feels like a tunnel. If this is your reason, you probably know it, and you may be a little ashamed of it. There's no need to be. Fear of dental treatment in particular is among the commonest fears there is.

It's also been studied well, and the findings help explain why it gets worse if you leave it. Jason Armfield, Judy Stewart and John Spencer surveyed a random sample of 6,112 Australians about their dental fear, their dental health and how they used dentists. They were testing the idea of a vicious cycle, and every link in it held up. People with more dental fear visited less often and waited longer between visits. They had worse oral health by their own account, and more need for treatment. When they did go, it was more likely to be because something hurt than for a check-up. About 29 per cent of the people who were very afraid of the dentist had delayed visiting, had poor oral health and only went when there was a problem. Among people with no fear, about 12 per cent had all three.

The cycle is easy to trace. Fear leads you to stay away, and staying away lets small problems grow into larger ones. Larger problems mean that when you're finally forced to go, because of pain, the visit involves more drilling, more injections and more discomfort than a check-up would have done. That experience confirms the fear, so you stay away longer next time. Someone who goes every year mostly has check-ups and the odd small filling, and their

experience of the dentist is mild. If you go once in five years, in agony, you have root canals and extractions. Your fear is an accurate report of your own experience, and the avoidance is what made the experience so bad.

I can't promise that a check-up after four years will find nothing. But the cycle runs in both directions. One ordinary appointment, even if it leads to a filling or two, begins to replace the bad memories with a duller one. After that, check-ups at whatever interval the dentist suggests keep the work small. On that point, the NHS says the gap between check-ups can be anywhere from three months to two years, depending on the state of your teeth and gums. You may have assumed you're supposed to go every six months and have been failing for years. The standard you've been failing may not apply to you.

As for the appointment itself, the NHS advice is short and sensible. Tell your dental team that you're anxious, and they'll be able to help you feel more comfortable. That sentence does more than you'd think. A dentist who knows you're frightened will generally explain what's coming, go more slowly, and agree a signal you can give to stop. Much of the fear is about being helpless in the chair, and a stop signal takes that away. Nervous patients are a large share of any dentist's list, so you won't be the first that week.

The same approach works for other procedures. If you dread the smear test, say so to the nurse. They're used to it, and there are things that help. You can ask for a smaller instrument, a different position, a longer appointment so there's no rush, or a friend in the room. If it's needles, tell the person taking the blood. They'd much

rather know than have you faint. You're allowed to ask for what would make it bearable. Nobody will think it precious of you, since an appointment that's bearable is one you'll come back for.

If the fear is severe, so that you can't even make the call without panic, it may be a phobia. Phobias respond well to treatment. A GP or the NHS talking therapies service can help, and some areas have dental services for very anxious patients. Getting help with the fear counts as getting the thing looked at.

The fear that gets you there and the fear that stops you

You might expect that the people who put off tests are the ones who don't worry enough. One careful study suggests something more interesting, and it changes what the task is.

Charlotte Vrinten, Jo Waller, Christian von Wagner and Jane Wardle worked with people who were part of a large British trial of bowel cancer screening. Nearly 8,000 of them filled in a questionnaire that measured three different aspects of cancer fear. One was whether they feared cancer more than other diseases. The second was whether they worried about cancer often. The third was whether they found thoughts about cancer uncomfortable. People were asked whether they'd accept an invitation to be screened. Some were then invited, and the researchers checked from clinic records who turned up.

The first two kinds of fear, fearing cancer more than other diseases and worrying about it a lot, made people more likely to say they intended to be screened. They more than doubled the odds. But neither made any difference to whether people attended. The third kind was different. People who found thoughts about cancer uncomfortable were no less likely to intend to go. But they were less likely to turn up.

So the people who stayed away weren't the unworried ones. They intended to go, and they couldn't bear to think about it. Intending takes a moment and can be done at a distance. Attending requires you to hold the subject in mind for long enough to read the letter,

make the arrangements and get yourself there. If the thought is painful enough that you flinch away from it each time, none of those steps gets done, however sincerely you meant to do them.

I think this describes the putting off precisely. You've never decided not to get the mole looked at. You've intended to for six months. What happens is that each time the thought comes, it's uncomfortable, and you move your mind off it within seconds. The respectable reasons from chapter 1 are how the moving gets done. Nothing gets booked, because booking would mean staying with the thought for the four minutes it takes.

If that's right, then the task isn't to become less afraid. I couldn't tell you how to do that, and you may have good reason to be afraid. What you need is to be able to stay with the thought for four minutes. Anyone can manage that, with a bit of preparation.

One piece of research suggests what the preparation might be. Jennifer Howell and James Shepperd ran three studies in which people filled in a risk calculator for a medical condition and were then offered the choice of seeing their result or not. The condition was fictitious, though the participants didn't know that. Some participants first did a short exercise that the researchers call affirmation. They reflected on something they valued about themselves or their lives. Those participants were less likely to avoid their results. The effect held even when the result might oblige them to do something unpleasant, and when the disease was described as untreatable.

The theory behind it is that threatening information is easier to face when your sense of yourself feels secure. If you've just been reminded of what matters to you and what you're good for, a piece of bad news is one fact among many. It doesn't feel like a verdict on your whole existence.

These were laboratory studies with an invented disease, and carrying them over to a real phone call is my step. But it costs nothing to try, and chapter 12 builds it in. Before you make the call, spend two minutes on who and what you're doing it for. Think of the people who'd want you to go, and the things you intend to be around for. Then dial while that's still in your mind.

What the putting off costs

I've left the costs until now because you know the main one already. If the thing is serious, delay can make it worse, and chapter 5 said so once. This chapter is about the costs you pay even when the thing turns out to be nothing, which is most of the time. They're easy to overlook because none of them arrives as a bill.

What follows is my own account, and I offer it as observation.

You pay in dread first of all. Chapter 1 described it. The thought comes back every week or two, and at ten past three it comes with force. Each visit is unpleasant and none of them settles anything. If the mole is harmless, which it probably is, then every one of those bad quarter-hours was unnecessary. A ten-minute appointment in March would have prevented six months of them. You've suffered many times the discomfort of the appointment, in instalments, in order to avoid it.

Here the habit has the shape this series keeps finding. I don't want to press the comparison with a drug, because nothing is being craved. But look at the sequence. The thought arrives and produces discomfort. You push it away with "it's probably nothing", and relief follows. The relief rewards the pushing away, so you do it again next time. Meanwhile the underlying discomfort grows, because the longer you've left it the more there is to be afraid of. The habit relieves, moment by moment, a dread that it's building up over months.

Then there's the checking. Many people who won't see a doctor examine the thing themselves, often. You twist in the mirror to look at the mole, or press the lump to see if it's changed, or search the internet at midnight and read the worst case. This gives you the anxiety of medical attention with none of the benefit. You aren't qualified to assess it, you have nothing to compare it with, and the internet can't see your shoulder.

You also lose a baseline. If you'd gone in March, there'd be a note on your record, perhaps a photograph and a measurement. If the mole changed later, there'd be something to compare it with. As it is, you stand at the mirror in September unable to say whether it's bigger than it was, because nobody recorded what it was.

The work grows, too. This is clearest with teeth, as chapter 7 described. A small cavity becomes a large one, and a large one becomes an infection. The treatment gets longer, more uncomfortable and more expensive at each step. Most adults in England pay towards NHS dental treatment, and the more complex the work, the higher the charge.

Shame accumulates. After six months you're no longer only someone with a mole. You're someone who has ignored a mole for six months. You start to imagine the doctor asking, "And how long has it been like this?" So there's a second thing to avoid, which is the admission that you've been avoiding. People stay away from dentists for years longer than they otherwise would, purely from dread of being told off. For what it's worth, clinicians see delay constantly and rarely comment on it. A simple "I've left this longer than I should have" covers it.

And the people around you may be carrying it too. If your partner knows about the mole, they've probably mentioned it more than once, and been put off more than once. They worry, and they can't make the call for you.

Against all of that, the putting off gives you the safe feeling. Chapter 3 showed that the feeling corresponds to nothing in your body. You pay for it in sleep and peace of mind, and sometimes in teeth, and very occasionally in much more than that.

The kit in the bathroom cabinet

Not everything that gets put off is a symptom. A good deal of it arrives in the post. There's the bowel screening kit, the letter inviting you for a smear test, the appointment for a mammogram, and the text about a health check. These are easier to ignore than a mole, because nothing is wrong. You feel fine, and the envelope goes on the side, then into a drawer.

Here's what the main programmes in England are, as the NHS describes them.

Bowel cancer screening is offered to people aged 50 to 74, every two years. It's a test you do at home. You collect a small sample and post it off, and the laboratory looks for traces of blood that you couldn't see. The NHS says it can help find cancer early, before you have any symptoms, which may mean it's easier to treat.

Cervical screening is offered to women and people with a cervix aged 25 to 64, every five years. The NHS describes it as a test to check the health of the cervix and help prevent cervical cancer.

Breast screening uses X-rays called mammograms to look for cancers that are too small to see or feel.

The NHS Health Check is a free check of the heart and blood vessels for people aged 40 to 74 who don't already have certain conditions. People should be invited every five years. It looks at your risk of problems such as heart disease and stroke, and you discuss how to lower it.

Add to those the dental check-up and the eye test, which you have to arrange yourself.

I need to say something here that a more one-sided book might leave out. Screening isn't a pure good, and deciding against a particular test is a legitimate choice. Every screening test produces some false alarms, which means anxious weeks and further tests for people who turn out to be fine. Some programmes also find slow-growing conditions that would never have caused trouble, and those then get treated. That's why the invitations come with information about benefits and risks, and why the programmes are offered as a choice. They aren't an obligation. A person who reads the leaflet, thinks it over and decides that a given test isn't for them has made a decision, and I've no quarrel with it.

That isn't what happens with the kit in the bathroom cabinet, though. Nobody read the leaflet and weighed the risks. The envelope went in the cabinet in June because opening it meant thinking about bowel cancer for ten minutes, and that's uncomfortable. It's the third kind of fear from chapter 8. There was every intention, and then a flinch away from the subject. In effect a decision has been made, because the test isn't getting done, but nobody made it.

This book is aimed at that kind of drift. People who consider a test and refuse it aren't my concern. So my suggestion for each outstanding invitation is to make it a real decision. Open the envelope and read what it says about benefits and risks. If you have questions, ask your GP surgery or ring the number on the letter. Then decide. If the answer is yes, book it or do the kit this week. If the answer is no, that's your right, and you can throw the letter

away with a clear mind and stop feeling guilty every time you open the cabinet. The one thing not to do is carry on as you are, which gives you neither the test nor any peace about it.

I'd expect that most people who look at it properly will decide to do it. The home bowel kit in particular asks very little. It's a few minutes in your own bathroom and a walk to the post box. The main obstacle is that you have to think about the subject while you do it, and chapter 8 was about getting through those few minutes.

"You can never get an appointment"

The fourth reason from chapter 2 was hassle, and I've no intention of telling you it's imaginary. In many places getting a GP appointment means ringing at eight in the morning, along with everyone else, and listening to a recorded voice for twenty minutes. Finding an NHS dentist who's taking new patients can be hard, and in some areas very hard. Getting time off work for an appointment is awkward. None of this is in your head.

Look at what the hassle does in the habit, though. It's the most respectable of all the reasons. It lets you say, truthfully, "I'd go, but you can't get an appointment." That closes the matter without any mention of fear. Try being honest with yourself about whether the hassle has ever stopped you from doing something you wanted to do. You've sat on hold for longer than twenty minutes to sort out a broadband fault, and you've queued for an hour for a concert ticket. The hassle is a real cost, and it's a small one. It's doing a bigger job than its size deserves, because it's standing in for the reasons in chapters 3 to 8.

The right comparison is between twenty minutes on hold, once, and six months of the thought coming back at ten past three. On those terms the phone queue is cheap.

There are also ways to reduce it. Services vary from place to place, so treat these as things to look into. I haven't checked the detail of any of them.

Many GP surgeries now take requests through an online form. You write what the problem is, how long you've had it and what you're worried about, and the surgery replies with an appointment, a phone call or advice. You can do it at ten at night, with no queue. For people who find the phone call itself the barrier, it's a gift.

The NHS App, where your surgery is connected to it, lets some patients book appointments and see their records.

If the matter isn't urgent, ask the receptionist for a routine appointment. People often assume the only appointments are the same-day ones released at eight o'clock. Many surgeries also book routine slots a week or more ahead. For a mole you've had for six months, a slot in three weeks is fine. The point is to have it booked.

A pharmacist needs no appointment, and can tell you whether something needs a doctor.

NHS 111 can direct you, and can arrange for you to be seen if it judges that you need to be.

For dentists, the NHS website has a search for practices near you. You may have to ring several to find one taking NHS patients, and in some areas you may not find one quickly. If you're in pain, NHS 111 can direct you to urgent dental care. If you can afford it, a private check-up is another route. If you can't, keep ringing round, and ask practices whether they keep a waiting list.

For screening, the invitation usually tells you how to book, and the bowel kit needs no booking at all.

As for work, a routine appointment can often be had at the start or end of the day, and most employers will let you go without fuss. If asking feels awkward, remember that "I've got a medical appointment" is a complete sentence. Nobody is entitled to ask what it's for.

One more point about the hassle, and it's my own view. The difficulty of getting an appointment is a reason to start sooner. If it takes three weeks to be seen, then your six months of delay becomes seven once you add the wait. Waiting lists for tests and referrals are long in many places. You can't shorten them, but you can control when you join the queue, and that depends on when you make the first call.

Making the call

Chapter 8 said the task is to stay with an uncomfortable thought for about four minutes, which is what booking takes. This chapter is about those four minutes, and then about the appointment.

There's good evidence that a specific plan makes the difference between meaning to and doing. Paschal Sheeran and Sheina Orbell tested it on exactly this kind of behaviour. They worked with 114 women registered at a medical practice in rural England who were due for cervical screening. All of them filled in a questionnaire about their intentions, and their motivation to attend was about equal across the group. Half were also asked to write down when, where and how they would make the appointment. The researchers then checked the medical records. Among the women who hadn't made a plan, 69 per cent attended. Among those who had, 92 per cent did. The two groups had the same intentions and the same fears. Writing one sentence about when and how raised attendance by twenty-three percentage points.

So before anything else, write the sentence. "Tomorrow at ten past eight, at the kitchen table, I'll ring the surgery on my mobile and ask for a routine appointment about a mole." It needs to be that specific, with a time, a place and a method. If you're using the online form, write "Tonight at nine, on the laptop, I'll fill in the surgery's form."

When the time comes, take two minutes first, as chapter 8 suggested. Think about who you're doing this for. They might be your children, or your partner, who has asked you three times. It

might be the holiday next year, or your own next thirty years. You're not psyching yourself up. You're reminding yourself that your life is large, and this is a small errand done on its behalf.

Then make the call. It can be short. "Hello, I'd like to book a routine appointment. I've got a mole that's changed and I'd like it looked at." If the receptionist asks for more detail, that's so they can book you with the right person. Give it plainly. If they offer a date three weeks away, take it. You can ask to be told of cancellations.

If ringing is beyond you at the moment, there are ways round it. Use the form. Go to the desk in person. Or ask someone to sit beside you while you dial. Some people find it easiest to have a partner or friend make the call with them in the room, and if that's what gets it booked, there's no shame in it.

Now the appointment itself. A few things make it more useful, and they come from common sense more than from research.

Write down beforehand what you've noticed, when you first noticed it and what has changed since. People go blank in consulting rooms. A note on your phone is fine.

Say the most important thing first. Appointments are short. If you've come about the mole, begin with the mole, and don't bring it up as you're standing to leave.

Say what you're afraid of, aloud. "I'm worried this might be skin cancer." This is the most useful sentence you can say, and the one people most often hold back. If you don't say it, the doctor may

reassure you about something you weren't worried about and leave the real fear untouched. Once you've said it, the doctor can answer it directly, with a yes, a no, or "here's how we'll find out".

Mention the delay if it's relevant, and then let it go. "I first noticed it in March." The doctor needs the timeline and isn't interested in making you feel guilty about it.

Before you leave, make sure you know what happens next. That might be nothing, or "come back if it changes", or a referral, in which case ask roughly how long it should take and what to do if you hear nothing.

If it helps, take someone with you. A second pair of ears is useful if there's anything to remember. For intimate examinations you can ask for a chaperone, and you can ask for a clinician of a particular sex. Surgeries are used to both requests.

The decision

Up to now this book has asked you to look at your reasons. This chapter asks you to decide something. It comes late because a rule given at the start, before the reasons had been examined, would have been pushed away as quickly as the thought of the mole.

The decision is this. **When I catch myself putting it off, I book it that day.**

The rule is attached to the catching, and that's deliberate. You can't stop the thought "I should get that looked at" from being followed by "but it's probably nothing, and the surgery's so busy". That sequence is a habit of years and will carry on running. What you can do is learn to hear it. The respectable reason, arriving within seconds, is the sign. From now on, when you hear yourself explaining why this week isn't the week, you take that as the signal to book.

It has four parts.

Clear the list. Go back to the list from chapter 1. Put it in order, with anything that's a change in your body at the top, then overdue check-ups, then unanswered invitations. Book the first item today, using the written plan from chapter 12. Then book one item a week until the list is clear. Doing one a week is manageable, and doing them all at once isn't. If anything on the list worries you a lot, put it first and don't wait for its turn.

The rule, from now on. Once the list is clear, the rule handles new things as they come. You notice something, you think "I should get that looked at", and you hear the reasons arrive. You book it that day. That might mean ringing, filling in the form, asking the pharmacist or using 111. What counts as booking is that by the end of the day the matter is in somebody else's hands and no longer only in yours.

Standing appointments. Some things come round on a schedule, such as the dentist, the optician and any regular review of a long-term condition. Book the next one before you leave the last. Dentists nearly always offer this. Then you don't have to decide afresh each time, and deciding afresh is where the putting off gets in.

Invitations. When a screening letter or kit arrives, open it the day it comes and make the decision described in chapter 10 within the week. Do the kit or book the test, or decide against it and throw the letter away. Don't leave it sitting in the cabinet.

Plans in the form "when this happens, then I'll do that" are well supported. Chapter 12 described one trial. Peter Gollwitzer and Paschal Sheeran later pooled 94 tests of such plans and found they made people a good deal more likely to follow through. Here are three to adapt.

When I hear myself say "it's probably nothing", then I'll say "then it'll be a quick appointment" and book it.

When I find myself checking the thing in the mirror or searching for it online, then I'll close the browser and write my booking sentence.

When a letter from the NHS arrives, then I'll open it before I take my coat off.

Here's what to expect, and I'll be careful, because I can't promise you an outcome. Making the first call will be unpleasant for about four minutes. The relief afterwards is usually immediate and larger than you expected, even though nothing has been examined yet. You'll have done your part, and the matter will be with someone else. For most of the things on your list, the appointment will end in reassurance or in some small piece of treatment. It's possible that one of them will turn out to need more. If so, you'll have found it sooner than you would have, and the next chapter is about that. I can't tell you that everything will be fine. I can say that the period of not knowing will come to an end.

Bad news, brush-offs and the opposite problem

The rule is simple. Some of what follows from it isn't, and I should be straight about that.

The wait for results. Between the appointment and the answer there may be days or weeks. There might be a referral, a scan or a biopsy. This stretch is hard, and it's the part people fear when they say they'd rather not know. Two things may help. The first is that a referral for tests isn't a diagnosis. The NHS says of breast clinic referrals that the tests usually show a lump is not cancer. Doctors refer when they can't be sure, and that's a low bar on purpose. The second is that this wait, unlike the last six months, has an end date, and you aren't carrying it alone any more. If it becomes hard to bear, tell someone close to you, and tell your GP. If you've heard nothing by the time you were told to expect, ring and ask. Letters do go astray.

If it's something. Sometimes it is. If that happens to you, I'm sorry, and I won't offer you cheer you haven't asked for. I'll say one thing. Going when you did was the best move available to you, and nothing about the diagnosis changes that. You may be tempted to blame yourself for the months before you went. Try to resist it. Nearly everybody delays. The reviews in chapter 2 show it's the normal human response, and hindsight makes the signs look clearer than they were. What matters from here is the treatment and the people around you. Your clinical team, your GP and the cancer charities all offer support for the fear as well as the illness, and it's there to be used.

If you feel brushed off. Sometimes you gather your courage, go, and come away feeling that you weren't listened to. The study in chapter 6 found that a dismissive consultation made people less likely to come back, which is the worst result it could have. If the problem persists, changes or gets worse after you've been told it's nothing, go back. You're not being difficult. The standard NHS advice for many symptoms includes returning if things don't improve. You can ask to see a different doctor. You can say, "I came about this two months ago and it hasn't gone away, and I'm still worried." A reasonable doctor will take a persistent symptom and a persistent worry seriously. If you feel seriously unheard, every surgery has a complaints process, and you're entitled to a second opinion.

Things that can't wait. The rule says to book it that day. Some things shouldn't be booked at all, because they need help now. The NHS says to call 999 for the chest pain symptoms listed at the front of this book. For anything else sudden or severe, or if you're not sure, NHS 111 will tell you what to do. You're allowed to use emergency services for an emergency, and you won't be wasting anyone's time.

The opposite problem. I said at the start that this book isn't for people with health anxiety, and I'll say why. The NHS describes health anxiety as spending so much time worrying that you're ill, or going to get ill, that it starts to take over your life. The signs it lists include constantly worrying about your health and frequently checking your body. They also include always asking for reassurance, worrying that doctors or tests have missed something, and obsessively looking up health information. For

someone in that pattern, "get it looked at" makes matters worse, because the reassurance never lasts and the checking feeds the fear. Some people swing between the two. They avoid for months, then check frantically, then avoid again. If you recognise yourself here, a GP or the NHS talking therapies service can help, and the NHS page on health anxiety has self-help steps. The treatment involves doing less checking. More appointments won't help.

Lapses. You'll put something off again. A letter will sit on the side for a fortnight, or you'll notice something and hear the reasons and go along with them for a week. That doesn't mean you're back where you started. The old habit had a long head start. When you catch it, the rule applies from that moment. Book it today, and don't spend any time scolding yourself for the fortnight.

If someone you love is the one putting it off. You can't make the call for another adult, and nagging tends to harden the avoidance. What sometimes works is to make it easy and keep it kind. "Would it help if I sat with you while you rang?" "Shall I drive you?" You might also leave this book where they'll see it.

The mole again

Here's the scene from chapter 1 again. It's an example of how it might go, and I'm not promising it. I've given it the likeliest ending, which isn't the only possible one.

It's a Tuesday morning in September, and you're getting out of the shower. In the mirror you catch sight of the mole on your left shoulder.

The thoughts run as they always have. You should get that looked at. It's probably nothing. The surgery's run off its feet, and work is mad this month.

You hear them this time, and you recognise them. They're arriving within seconds, and every one is respectable. You know now that this is the signal.

You get dressed. At the kitchen table you write one line on the back of an envelope. "Today, 8.10, at this table, I ring the surgery and ask for a routine appointment about a mole." You think for a minute about your daughter's wedding next summer, and about the walking holiday you've been promising yourself, and about being around. At ten past eight you ring. You're on hold for fourteen minutes, and you unload the dishwasher while you wait. "I'd like a routine appointment, please. I've got a mole that I think has changed." They offer you a week on Thursday at ten to nine. You take it.

You put the phone down, and you feel lighter, which surprises you. Nobody has looked at anything yet, and the mole is exactly what it was at eight o'clock. But for the first time since March it's somebody else's job to worry about it.

A week on Thursday you sit in the consulting room with your shirt off your shoulder. "I first noticed it looked different in March," you say. "I'm worried it might be skin cancer." The doctor looks at it under a bright light through a small lens, for perhaps forty seconds. She asks a couple of questions. Then she says she's not concerned. It's a harmless kind, and it has the regular look she'd expect. She takes a photograph for your record so there's something to compare with. If it changes, come back. You're out by five past nine.

It took six months of ten past threes to get to a forty-second look.

That evening you take the screening kit out of the bathroom cabinet and read the leaflet, and the following morning you post it. At the weekend you ring three dental practices, and the third can see you in November.

It won't always end with "I'm not concerned". Sometimes the doctor will say, "I'd like someone else to look at that." That's the system doing its job, and you'll be glad you didn't wait until Christmas. But much more often than not, what you've been dreading for months will be settled by a short conversation in a small room. The relief afterwards is the lasting kind.

If you do one thing after closing this book, take the item at the top of your list and write the sentence. Put in when you'll book it, where you'll be and how you'll do it. Then, at the time you've written down, make the call.

Notes

This book gives general information. It isn't medical advice, and it's no substitute for a doctor, dentist, pharmacist or nurse who can examine you. If you think something may be an emergency, call 999 or use NHS 111.

I've kept sources out of the chapters where I could so they read easily. Here they are by chapter, with the limits I'm aware of. Unless I say otherwise, I read the published summary of each paper and not the full text. I checked each paper for a retraction notice in September 2026 and found none. Where a chapter isn't listed, it rests on my own reasoning. That includes chapters 1, 3, 9, 13 and 15 apart from the sources named in them. The NHS and Cancer Research UK pages were read in September 2026. They describe services in England. Screening ages, booking arrangements and charges differ elsewhere and change over time.

Before you start. The 999 criteria are from the NHS page "Chest pain". The description of health anxiety is from the NHS page "Health anxiety".

Chapter 2. Taber, Leyva and Persoskie, "Why do people avoid medical care? A qualitative study using national data", *Journal of General Internal Medicine* 30, 2015, pages 290 to 297. The survey was American, where cost and insurance are much larger barriers than in the NHS. Of 1,369 people, 58.4 per cent named traditional barriers such as cost and time, 33.3 per cent gave unfavourable evaluations of seeking care, and 12.2 per cent reported low perceived need. Smith, Pope and Botha, "Patients' help-seeking

experiences and delay in cancer presentation: a qualitative synthesis", *Lancet* 366, 2005, pages 825 to 831. The list of four reasons is mine.

Chapter 3. Persoskie, Ferrer and Klein, "Association of cancer worry and perceived risk with doctor avoidance: an analysis of information avoidance in a nationally representative US sample", *Journal of Behavioral Medicine* 37, 2014, pages 977 to 987. The pattern I describe was found in people aged fifty and over. In younger people it was perceived risk, and not worry, that went with avoidance. It's a survey and can't show cause.

Chapter 4. The statements about moles and breast lumps are from the NHS pages "Moles" and "Breast lump". The comparison of the two kinds of relief is mine.

Chapter 5. The survival figures are from the Cancer Research UK page "Why is early diagnosis important?", which draws on NHS England's "Cancer survival in England" for cancers diagnosed from 2016 to 2020. They're age-standardised net survival for stage 1 against stage 4. Neal and twenty colleagues, "Is increased time to diagnosis and treatment in symptomatic cancer associated with poorer outcomes? Systematic review", *British Journal of Cancer* 112, supplement 1, 2015, pages S92 to S107. Hanna and nine colleagues, "Mortality due to cancer treatment delay: systematic review and meta-analysis", *BMJ* 371, 2020, m4087. The remarks about fillings and blood pressure are general knowledge and I haven't sourced them beyond the NHS pages "Dental check-ups" and "NHS Health Check".

Chapter 6. Cromme, Whitaker, Winstanley, Renzi, Smith and Wardle, "Worrying about wasting GP time as a barrier to help-seeking: a community-based, qualitative study", British Journal of General Practice 66, 2016, pages e474 to e482. What I say about pharmacists, online forms and how clinicians regard embarrassment is my understanding and isn't sourced.

Chapter 7. Armfield, Stewart and Spencer, "The vicious cycle of dental fear: exploring the interplay between oral health, service utilization and dental fear", BMC Oral Health 7, 2007, article 1. It's a survey taken at one point in time, so it's consistent with a cycle and can't prove one. The check-up intervals are from the NHS page "Dental check-ups". The advice to tell the dental team you're anxious is from the NHS page "What happens when you visit the dentist". The options for cervical screening are from the "What happens" page of the NHS guide to cervical screening. That some areas have dental services for very anxious patients is from my general knowledge and I haven't checked it.

Chapter 8. Vrinten, Waller, von Wagner and Wardle, "Cancer fear: facilitator and deterrent to participation in colorectal cancer screening", Cancer Epidemiology, Biomarkers and Prevention 24, 2015, pages 400 to 405. The odds ratio for attendance among people who found thoughts of cancer uncomfortable was 0.72. The screening in that trial was an examination with a flexible camera, not the home kit now used. Howell and Shepperd, "Reducing information avoidance through affirmation", Psychological Science 23, 2012, pages 141 to 145. Applying it to a real phone call is my step.

Chapter 9. That most adults pay for NHS dental treatment, in three bands by complexity, is from the NHS page "How much NHS dental treatment costs".

Chapter 10. The descriptions are from the NHS pages "Bowel cancer screening", "Cervical screening", "Breast screening (mammogram)" and "NHS Health Check". What I say about false alarms and about finding conditions that would never have caused harm is a general statement about screening. I haven't sourced it, and the balance differs between programmes. The leaflet sent with each invitation is the place to read about a particular test.

Chapter 11. None of the practical routes was checked in detail, and the chapter says so.

Chapter 12. Sheeran and Orbell, "Using implementation intentions to increase attendance for cervical cancer screening", *Health Psychology* 19, 2000, pages 283 to 289. The advice about the appointment itself is mine.

Chapter 13. Gollwitzer and Sheeran, "Implementation intentions and goal achievement: a meta-analysis of effects and processes", *Advances in Experimental Social Psychology* 38, 2006, pages 69 to 119. The rule and its four parts haven't been tested together, and what I say to expect is my expectation and not a finding.

Chapter 14. The statement about breast clinic tests is from the NHS page "Breast lump". The signs of health anxiety are from the NHS page "Health anxiety".