Editor's Briefing

Thomas Round

DIAGNOSIS; STILL OUR ACHILLES HEEL?

This is my first Editor's briefing since joining the *BJGP* as Associate Editor and it is a pleasure to introduce our theme of diagnosis, such an important part of our role as GPs, and yet an area which has been argued is also our 'Achilles heel'.

It was 50 years ago that John Howie, Emeritus Professor of General Practice at the University of Edinburgh, published 'Diagnosis — the Achilles heel?'[1] He argued that the decision to prescribe for a set of symptoms frequently preceded the allocation of a diagnostic label, that is, the diagnosis followed the prescription. In his brilliant follow-up piece 'After Achilles'[2] 6 years ago, former Editor of this Journal and esteemed colleague Professor Roger Jones, argued that *'general practice has floundered among unhelpful phrases such as "tolerating uncertainty", "using time as a diagnostic tool" and "letting the diagnosis emerge" … this approach to diagnosis is sloppy and idle'*, while calling for a paradigm shift in our approach to diagnosis. With all that has gone on over the past 6 years perhaps now is a good time to reflect on whether we are now 'After Achilles'?

With an increasing number of telephone and online consultations driven forward by the pandemic is there a risk these more transactional approaches could hinder diagnosis? While we have seen work into developing clinician decision support tools and technological advancement, contrary to some technology company pronouncements, there is still nothing more important than the core clinical consultation with active listening, empathy, and honed acumen. No amount of online tools will replace this.

Primary care often feels like being between a rock and a hard place. We are criticised for missing a diagnosis yet are pressured not to refer too much, and we are all keenly aware of the pressures on the healthcare system and finite resources. While gatekeeping can be a real strength for containing healthcare resources there is some evidence that if done too firmly it can lead to delays in diagnosis for serious conditions like cancer. Perhaps we need to reframe the discussion, and perhaps the GP and the expanding and wider primary care team are more about *gate opening* for patients? Particularly to aid appropriate diagnostic testing.

With a decreasing pool of GPs, heavy workload pressure, and time pressured consultations it can sometimes be difficult to make a firm diagnosis and sometimes easy to fall into cognitive biases. We must nurture safety netting, gut feeling, and relational continuity of care — and where appropriate, supplement with use of decision support and appropriate diagnostic testing and referral. Truly then we can reach a sweet spot of both person-centred and technological diagnostic approaches, and perhaps be 'After Achilles'.

Issue highlights

There is an excellent selection of papers covering issues around diagnosis this month. Some highlights within the area of cancer include myeloma diagnosis, symptom appraisal and help seeking in older adults with potential cancer symptoms, melanoma risk assessment, and impacts of COVID-19 lockdowns. A key area in the diagnostic journey are investigations, with work presented on communication of blood tests to patients. The importance of clinical diagnosis is made by the CHECK cohort, where *'radiographs provided little assistance with help to identify patients with hip OA* [osteoarthritis] *among patients who recently presented with hip or knee complaints'*.

Thomas Round,
Associate Editor, *BJGP*

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2. Jones R. After Achilles. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp16X683869.

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