Accurate diagnosis needs much more than regulated algorithms and procedures

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All too often our attractive sounding plans and policies become undertowed by an unconsidered flaw. Healthcare is recurrently subject to this: The Law of Unintended Consequences.

Here is a recent example.

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Accurate diagnosis needs much more than regulated algorithms and procedures

In 2020, in the thick of the Covid lockdown, a previously healthy, articulate and competent twenty-seven-year-old woman, Jessica Brady, died of a massively disseminated adenocarcinoma. This happened despite, in the previous months, having contacted her NHS GP surgery more than twenty times. Yet the diagnosis was made only shortly before her death. Her gathering symptoms had, for some months, been assessed and 'managed' almost entirely by telephone or texted consultations.

Jessica's tragically bereaved mother then, with admirable far-sight and fortitude, launched a 'never again' campaign recruiting both relevant governmental bodies and the Royal College of GPs. The fruits of these contacts were briefly publicised by the media, quoting all three participants, in late September 2025. Thoughtful contrition and lament segued to a pragmatic guiding principle for doctors: 'Three strikes and rethink' whenever a patient's symptoms persist in outflanking diagnostic clarification or prediction. The Health Secretary, Wes Streeting, underpinned this by expressing a resolute principle: 'Patient safety must be the bedrock of the NHS'.

All of this is desirable and sensible, surely? Yet although few will dispute such aims or maxims they may here turn out to be more virtuous than useful, for they do not address how it is that a group of doctors could, collectively, render and relay such egregious diagnostic failure. Unless and until we understand this we remain stalled with 'never again' aspirations and slogans. We must better understand before we can correct.

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Here are some crucial factors that initial accounts and analysis of this shocking failure did not identify: the absence of both face-to-face contact and personal continuity of care, and thus personal familiarity. No one then could directly see or sense this unfortunate woman's whole mien – how she was – or what had become uncharacteristic of her – how she had changed. Each doctor was dealing with a largely depersonalised and decontextualised snapshot: a 'new' consultation. In such a siloed, production-lined service, deprived of ongoing personal observation and contact, it becomes all-too-easy to miss the significance of apparently common and transient symptoms that in fact herald the very serious. And yet that is how so many of our mortal illnesses present.

Handling this needle-in-the-haystack predicament is the eternal conundrum of general practice The erstwhile skills to meet this complex challenge evolved to procure and conduct an ever-changing mixture that could be technically described as the objectively generic and the (inter) personally constructed and shared. That meant knowing about both medical science *and* the particular person who was suffering – that is what enabled those doctors then to be far more effective in 'protecting patients from hospitals, and hospitals from patients' ie they would be better able to judge when to delay and deflect more intensive intervention, and then when to assert or accelerate it. In Jessica Brady's case the haplessly humanly-detached succession of remotely signalling doctors proved incapable of making this judgement accurately – clearly there was no meaningful protection for anyone. As it is most unlikely that *all* the involved doctors were negligent or incompetent, the

failure is almost certainly due to their working systems and conditions, their modus operandi.

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Some will hasten to point out that this severe service-casualty was largely due to the unprecedented strictures of Covid. There is truth in this, but a greater truth arises from it: for the imperative Covid precautions demanded that we rapidly develop our technological applications to provide remote healthcare assessments and responses – this was achieved and implemented with remarkable facility; but this success then served to fortify and validate the subsequent plans and vision of those who see healthcare predominantly in terms of applied technology. Hence our post-Covid NHS has been expedited to something far more personally remote, disconnected and inaccessible than it was previously.

This personal distancing in favour of remotely administered and delivered procedure can work very well with problems that are clear, straightforward and typical. But so often how illnesses present, or how they evolve, are none of these: rare and very serious problems seem, initially, commonplace; the seemingly severe turns out 'transient and trivial'; the psychosomatic is, by its nature, refracted and in code. In all these examples the kind of personal familiarity and rapport that come from personal continuity of care can be a crucial ally, both diagnostically and therapeutically.

Very frequently this is evident with 'somaticizers', whose many fluctuating symptoms respond best – after due clinical vigilance – to empathic reassurance,

explanation and containment. Previous era GPs commonly identified such familiar patients with their thick folders – perhaps unkindly they were sometimes called 'heart-sink'; currently they would be designated 'Medically Unexplained Symptoms'. The better erstwhile GPs could then protect both such people and the hospitals from one another with greater accuracy.

Such therapeutic containment and accuracy becomes less and less possible as we lose personal familiarity and bonds with one another, and replace these with carouselled staff working remotely and commanded by prescribed procedures, algorithms … and increasingly deferring to artificial intelligence.

What, then, will be the result of 'Three strikes and rethink'? The results are likely to be very mixed. There will be some severe illnesses fortuitously identified earlier. But these benefits will be undermined by another tendency….

If primary healthcare continues to become more remote and procedural – *no-one-knows-anyone-but-just-do-as-you're-told-and-allow-the-algorythm* – there will be more 'false alarms' raised, thus putting yet more (unnecessary) pressure on hospital services. This is because doctors who do not know their patients are much less well-placed to perceive bigger and deeper pictures – contexts – or to be able to maintain any kind of vigilant, containing, watchful-waiting to see what is happening. Where the parties are unknown to one another the threshold for alarm-triggers becomes much lower – there is 'safety' (for the practitioner at least) in arranging more tests or passing the patient on. Other things then increase: rapid default to specialist referral and investigations, the consequent exposure of ambiguous, coincidental 'new' pathology; the provocation of illness-anxiety and behaviours – the nocebo effect;

unnecessary treatments and thus iatrogenesis … all of this creates extra demands, stress and financial burden across our health services.

Policies, prescriptions and procedures are often essential in our healthcare. Yet they are often not sufficient: there is so much else to best help our engagement and understanding of others.

Our heedlessness of this truth is now stymying much of our healthcare's quality and effectiveness.

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