One can only hope that a grade school education is required to order an imaging study.

There I was, somewhere in the thick of my nightly teleradiology workload. Opening my umpteenth CT pulmonary angio, I saw provided in the clinical history: “Loopus.”

I couldn’t help but feel a smidge of gratitude that somebody had bothered to give information beyond the usual “R/O PE,” which conveys nothing at all. It wasn’t the first time, for want of a detailed history provided by a medical professional, I had to settle for less-than. As an intern, for instance, I once received a case sent from a nursing home with absolutely no documentation from their staff as to why the transfer had occurred. My best clue was a faint copy of the ambulance paperwork, on which the EMT had written “Fall down go boom.”

Then, there was the time I was on a nuclear medicine rotation during my residency. Lacking any guidance from the referrer of a bone scan-patient, I turned to the questionnaire filled out by the patient herself, on which she had listed the areas of her pain. Seeing her handwritten “My kneeses” was both clinically relevant and entertaining.

Maybe it’s too hopeful of me to conclude that, when somebody in healthcare can’t properly string two words together (or correctly spell one, even if assisted by Google), s/he couldn’t possibly possess the education and credentials supposedly needed to order imaging studies. I might be wrong…I’ve lost track of just how far the usage of “physician extenders” has progressed. Perhaps one now needs nothing more than the ability to scrape a pen over paper or poke a button on a computer terminal.

Still, presumably such folks are not (yet) permitted to do so independently, and individuals like my anonymous “Loopus” writer are only doing as specifically told by a physician or someone otherwise rightfully capable of ordering medical imaging to be done. In other words, under supervision. Except that supervision seems to be increasingly theoretical.

For one thing, I suspect a physician would, upon seeing an order in his name utilizing spelling worthy of a grade-school student, speak up. Perhaps out of a deep-seated sense of wanting to share knowledge (did anyone making it through residency not have teaching responsibilities at some point?)…or perhaps because of the embarrassing thought that the radiologist might see the error and think the referring clinician to be a blithering idiot.

More importantly, it doesn’t seem too great a leap of logic that a clerk lacking the ability to spell medical terms properly (or interest in learning how!) is likely to be willing to abridge other things the supervising physician might have wanted in the clinical history. After all, if the clerk doesn’t understand what s/he’s been told to write, what’s the chance the clerk will recognize the importance of including specific words and phrases, as opposed to casually omitting them?
I suspect this accounts for no small number of instances wherein I have spoken to referring clinicians and learned that they are mystified and/or peeved that they provided detailed histories on their patients (“Inversion injury left ankle, pain and tenderness lateral malleolus”), only to see our dictated reports with far less (“Provided history: Pain”). Somewhere in the chain of communication, information is being lost, and I think it’s entirely worthwhile to track down and fix these leaks. For lack of a better place to start, I think “loopus” should never cross our path again, so with a tip of the hat to Bill Maher, I propose New Rule #1 for ordering imaging studies: If you can’t spell it, you’re not allowed to order it.


Links: