Letter to the Editor

Scheduling Problems in Diagnostic Imaging

The article by L. David Wells in the March *Journal* (*1*), presented certain problems that are common to all hospitals: the coordination of diagnostic testing.

In a time when medical costs to the patient are at an all time high, we must make every effort to utilize the most effective means of cooperation and coordination in diagnostic testing. Computerization of patient scheduling is very useful in departmental communication. By coordination of schedules, the patient's hospital stay is kept to a minimum, thus reducing his hospital bill.

In looking at the problems of patient scheduling, a common denominator appears. There are human beings performing the integral step of scheduling. Most of the problems stated in Table 1 happen because of errors made by personnel and physicians. All of the problems are failures in communication by a key person, whether it was a nurse, a nurse's aide, a transportation aide, a technologist, or a physician. These errors unduly delay the best planned schedules.

One of the major problems of scheduling stems from the physician. The physician, in all cases, is the starting point of a patient's orders. His orders should be exact and state what tests are desired. Unfamiliar or vague terminologies in a physician's written orders and illegible handwriting are two common causes for delay in the scheduling process. As an example, the physician orders a nuclear medicine procedure by writing "radionuclide scan" or "technetium scan." The ward clerk, the nurse, or the technologist must then call the physician to clarify his orders. The physician also delays the process by ordering tests all at the same time or out of proper sequence. The most common error is to have the patient undergo a barium enema one day and order a liver scan the next day. The physician even further delays the process by ordering all of his tests "stat." As more and more diverse modalities, such as nuclear magnetic resonance, emission computed tomography, pulsed doppler, and other new innovations become available, scheduling difficulties will continue to increase. As Mr. Wells said, communication and education will play a necessary role for all persons concerned.

Examinations are performed on the wrong patient from time to time and we are all sadly aware of this. A simple and effective method to prevent this is to have personnel check the patient's chart for written orders prior to starting any diagnostic test. If there is no written order, the test should not be performed, no matter what paperwork has been generated. This is the technologist's responsibility and obligation to the patient.

Mr. Wells also stated that the cost for these procedures increases when the exams are ordered out of sequence, canceled, or ordered wrongly. This statement is erroneous. The actual cost of the scan should not change due to these factors. The only thing that increases is the patient's hospital bill due to longer hospital stay, additional preparations, and additional x-rays. The example in Table 3 would reflect an approximate addition of $100 to the patient's bill if the patient had to stay an additional day, not a mere $12.

Effective scheduling is only one part of quality patient care. Quality care is administered by qualified and caring medical personnel. We, as nuclear medicine technologists, offer the patient more than button pushing. Our patient care consists of adjusting IV solutions, regulating oxygen, bed pan duty, and even CPR when necessary. We are mature adults who can recognize other areas of patient need such as comfort and reassurance. If a checklist such as in Table 10 is necessary in a nuclear medicine department, the department is staffed by poorly trained technologists or led by narrow-minded management.

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Reference

1. Wells LD. Quality assurance in scheduling nuclear medicine examinations. *J Nucl Med Technol* 1982; 10:28–32.