Renshaw et al\(^1\) mention a case in litigation, arising from (mis)treatment of a patient based on a report in which the word no was absent. I am also aware of litigation arising from an accurate transcription that was lost in translation. A firearm incident prompted the forensic autopsy of a previously healthy young man. His distraught family insisted on reviewing all reports, and their distress increased upon seeing that an organ block had been preserved for museum purposes. We know what this means; the public does not. “Medical” words with multiple meanings and/or nuances can be even more problematic in an international setting, but this topic belongs to a much longer manuscript.

Fortunately, Renshaw et al\(^1\) demonstrated that word choice and dictation habits can change with effort. Subsequent weak links in the report-generating process should also be investigated. It is regrettable that doctors at many institutions have lost control of transcription quality. At various blood centers where I have worked, senior executives had the best administrative assistants; lesser talent was assigned to help the medical staff. Perhaps this made me more vigilant about reviewing documents. I generally caught secretarial errors—some of them humorous—but as anyone who publishes knows, it is harder to catch one’s own mistakes. Perhaps a variation of Amazon.com’s “statistically improbable phrases” algorithm\(^3\) could be adapted to scan and flag pathology reports.

Conventional wisdom says that a picture is worth a thousand words. Pathologists, on the other hand, study thousands of pictures to compose sentences of few words. We also verbally interpret vast numerical arrays from our laboratories. Language—not “pushing glass” or “crunching numbers”—is our most important connection to the rest of medicine. Improving the standards of medical communication certainly fits the vision of transformation embraced by College of American Pathologists (CAP) thought leaders and articulated by CAP President Stephen Bauer, MD\(^4\).

Let’s do justice to the words of Timothy Allen, MD, JD; Megan Renshaw; Edwin Gould, MD; and Andrew Renshaw, MD, by continuing the debate. As I learned from a beloved mentor in transfusion medicine, Breannndan Moore, MD\(^5\) if and when we disagree (in his case, “when”), there can only be one winner: the patient.

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