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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии

საქართველოს სამედიცინო სიახლენი

GEORGIAN MEDICAL NEWS

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GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GMN: Медицинские новости Грузии - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНИТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

GMN: Georgian Medical News – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНИТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებიდან.

WEBSITE

www.geomednews.com

К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman** (**Кириллица**), для текста на грузинском языке следует использовать **AcadNusx.** Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи**. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - http://www.spinesurgery.ru/files/publish.pdf и http://www.nlm.nih.gov/bsd/uniform_requirements.html
В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректура авторам не высылается, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.

REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or compu-ter-printed on a single side of standard typing paper, with the left margin of **3** centimeters width, and **1.5** spacing between the lines, typeface - **Times New Roman** (**Cyrillic**), print size - **12** (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf
In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

Articles that Fail to Meet the Aforementioned Requirements are not Assigned to be Reviewed.

ავტორთა საყურადღებოდ!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დავიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე,დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx.** შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შეღებვის ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფჩხილებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

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NAMING CONVENTIONS FOR UNIDENTIFIED PATIENTS IN EMERGENCY AND TRAUMA SETTINGS: A NARRATIVE REVIEW

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Abstract.

Unidentified patients pose unique challenges in emergency and trauma care, where rapid registration and treatment initiation are essential despite the absence of formal identification. Naming these patients is critical for safe clinical care, communication, and legal documentation. This narrative review synthesizes the literature on who unidentified patients are, the issues associated with naming them, and the naming systems currently used. Studies consistently describe these patients as predominantly young males presenting with trauma, substance misuse, or altered consciousness, often from socially vulnerable groups. While naming enables care delivery, existing practices—including generic placeholders like John/Jane Doe and various structured systems such as NATO phonetic codes or randomized aliases—carry risks of duplication, operational confusion, and misidentification, potentially leading to treatment errors and delays. Policy recommendations advocate for unique, randomized naming systems, yet there remains a lack of comparative evaluation and standardization across settings. Future research should focus on assessing the safety and usability of different naming systems and developing internationally harmonized frameworks to enhance patient safety and dignity in routine and mass casualty contexts.

Key words. Unidentified patients, patient naming conventions, alias assignment, John Doe, trauma, emergency department, patient safety, electronic medical records, operational challenges, narrative review.

Introduction.

Unidentified patients present a unique challenge within healthcare systems, particularly in emergency and trauma settings where rapid decision-making is critical [1]. These patients arrive without verifiable identification due to factors such as trauma, unconsciousness, intoxication, or social vulnerability, necessitating immediate registration under temporary aliases to initiate care [2]. Naming unidentified patients is essential not only for administrative purposes but also to ensure that investigations, treatments, and documentation are accurately linked to the correct individual, facilitating communication among multidisciplinary teams and maintaining patient safety [3].

Despite the centrality of naming in patient management, current practices vary widely, ranging from generic placeholders such as "John Doe" or "Jane Doe" to structured naming systems using phonetic codes or randomised aliases. However, these naming systems are not without risk [4]. Duplicate or similar temporary names can lead to misidentification, delays in treatment, transfusion errors, and operational confusion within electronic medical records (EMR)[2]. While various systems have been proposed to mitigate these risks, including policy recommendations advocating for unique, non-sequential identifiers, there remains a lack of standardisation and comparative evaluation across healthcare settings [5].

This narrative review aims to synthesise the existing literature to address the following questions: Who are the unidentified patients presenting to hospitals? What issues are associated with naming them? And how are these patients currently named in practice? By exploring these themes, this review seeks to highlight existing gaps in evidence, inform policy and practice, and propose directions for future research to ensure safe, effective, and dignified care for this vulnerable patient population.

Review.

This narrative review was conducted to synthesise literature on unidentified adult patients in hospital settings, focusing on their demographics, the issues associated with naming them, and the naming systems used. Relevant studies were identified through targeted searches of PubMed, Scopus, Embase, and Google Scholar using keywords such as “unidentified patient,” “unknown patient,” “alias assignment,” “naming conventions,” and “emergency department.” Inclusion criteria encompassed English-language articles describing patient demographics, operational challenges, or naming systems for unidentified patients in hospital or trauma settings. Policy documents and institutional reports were also reviewed to capture current practice recommendations. Articles focusing solely on forensic identification were excluded. Data were extracted narratively and synthesised under the themes of who unidentified patients are, why naming is needed, issues arising from naming practices, and current naming systems described in literature or policy.

Who are the unknown patients?

Unidentified patients presenting to emergency departments are predominantly young males with a high prevalence of trauma and substance misuse [6]. Acar and Tekin (2024) [7] reported that among 1324 unidentified patients with altered consciousness in Turkey, approximately 70% were male with a mean age of 28 years, and notably, 80% were immigrants or foreign nationals, with trauma, assaults, and drug-related presentations common. Claps and Berk (1992) [6] found similar patterns in the US, where 71% of 344 unidentified ED patients were male with a mean age of 37 years, presenting most commonly with major trauma, cardiac arrest, or drug overdose, and high associated mortality. Tastad et al. (2021) [8] in Canada reported that most unidentified patients were male (65%), mean age 32 years, with presentations dominated by substance misuse (33%) and trauma (25%); while most eventually self-identified, 13% died within 30 days. Janowak et al. (2017) [2] found that trauma patients

admitted as 'John Doe' were often younger, predominantly male, uninsured, with severe injuries and high intoxication rates, resulting in longer hospital stays, higher complication rates, and greater discharge care needs. Additionally, studies such as Brooks et al. (1999) [9] and Robinson et al. (1985) [10] noted that unidentified patients often arrive via trauma or mass casualty pathways where immediate registration is required before identity is confirmed. Overall, these studies highlight that unidentified patients are a high-risk, vulnerable population, often critically ill or injured, intoxicated, socioeconomically marginalised, and requiring urgent care despite lacking formal identification at presentation.

Why do we need to name unidentified patients?

Assigning a name to unidentified patients is essential for safe and effective clinical care. Multiple studies highlight that without a registered identity, patients cannot be formally admitted into hospital systems, investigations and treatments cannot be ordered or linked correctly, and continuity of care is jeopardised [6,7]. Acar and Tekin (2024) [7] noted that immediate registration enables urgent diagnostics and interventions for critically ill trauma patients. Claps and Berk (1992) emphasised that naming is needed to initiate investigations, treatment, and legal documentation in emergency settings [6]. Tastad et al. (2021) observed that lack of identification impacts physician efficiency, medication safety, diagnostic accuracy, and discharge planning [8]. Janowak and Janowak (2019) further described that unique temporary names are necessary to prevent lab, imaging, and blood bank misattribution, which can lead to life-threatening errors [11]. Moreover, studies highlight that robust naming ensures clear communication among multidisciplinary teams, enables legal and billing processes, and protects patient dignity and identity continuity throughout care [9,10]. Thus, naming is not merely administrative but a critical patient safety practice enabling timely, accurate, and accountable healthcare delivery.

Issues with naming unidentified patients.

Despite the necessity of naming unidentified patients, current naming practices pose significant operational and safety risks. Janowak et al. (2019) surveyed trauma providers and found that over half believed DOE (John/Jane Doe) naming causes serious confusion, with 31% experiencing actual confusion and 4% reporting patient care errors [12]. Nurses and resident physicians reported higher confusion and mistake rates, particularly when all trauma patients were assigned aliases rather than only unidentified ones. Janowak and Janowak (2019) described a critical case where two unidentified patients registered under "Doe" names caused operating room delays, blood bank mismatches, and nearly led to wrong-patient surgery [11]. Rogers et al. (2024) highlighted operational challenges with placeholder naming (Patient + room number), including transfusion errors due to unrealistic DOB assignments, lab result misinterpretation when sex was entered as "Unknown," and order cancellations when merging temporary records with confirmed identities [13]. Landman et al. (2015) reported near-miss events during the Boston Marathon mass casualty incident when EMR systems displayed only the first character of aliases, making patients indistinguishable on electronic boards [14]. Furthermore, Robinson et al. (1985) and Brooks et al. (1999) noted that sequential or similar alias names caused confusion in busy trauma settings, particularly in blood banks where misidentification could be fatal [9,10]. Collectively, these studies demonstrate that poorly structured or duplicated naming systems increase the risk of misidentification, treatment delays, and critical medical errors, underscoring the need for robust, unique, and standardised naming conventions.

How do we name unidentified patients?

A range of naming systems have been developed to reduce duplication and enhance safety when registering unidentified patients. Historically, generic placeholders such as "John Doe" or "Jane Doe" were widely used, but these risk duplication, especially in mass casualty or busy trauma settings [6]. Robinson et al. (1985) developed an alias system using modified NATO phonetic first names (e.g. Alpha, Beta, Channel) combined with written-form numbers as surnames (e.g. One, Two), creating over 2500 unique combinations [10]. Brooks et al. (1999) implemented a system assigning "Unknown Male/Female" as a prefix, a NATO phonetic code (e.g. Foxtrot), and the admission date, such as "Unknown Male Foxtrot 23/4," enabling rapid communication and preventing duplication [9]. Blank-Reid and Kaplan (1996) described using "Unknown" as a last name with preassigned human first names (e.g. Abigail, Bob) to satisfy computer requirements for gender-specific names and avoid impersonal or confusing aliases [15]. Landman et al. (2015), after operational failures during the Boston Marathon MCI, introduced a revised naming system where first names were "Unknown" and last names included a unique meaningful word (e.g. Unk-M-Purple), ensuring distinct EMR displays [14]. Rogers et al. (2024) highlighted that their system used "Patient" as the first name and room number as surname (e.g. Patient Ten) but faced challenges including transfusion errors and lab flagging issues [13]. Policy recommendations, such as the NHS Patient Safety Alert (2018), advocate for randomised, non-sequential temporary names combined with unique numeric identifiers to prevent duplication and ensure interoperability [16]. See the table 1 for more details. Overall, while multiple systems exist, comparative evaluations are lacking, and standardisation remains absent across institutions and countries.

Patient Perspectives and Dignity.

Although research on patient experiences with temporary aliases is limited, available evidence suggests that anonymity in emergency settings can affect perceptions of dignity and personhood. For example, Gale (2021) argued that "Doe" naming practices may feel dehumanizing, emphasizing the ethical obligation to restore identity as soon as possible. Similarly, Kumar et al. (2024) highlighted the distress experienced by families in India when unidentified patients were managed under anonymous labels, underscoring the link between naming conventions, family communication, and patient dignity. While structured alias systems are designed to improve safety and efficiency, future research should also consider how patients and families experience these temporary identities, ensuring that operational gains do not come at the expense of dignity or patient-cantered care.

Table 1. *Summary of Naming Systems for Unidentified Patients in Emergency and Trauma Settings.*

Naming System	Example	Attributes	Benefits	Drawbacks
Generic placeholders (John/Jane Doe, Unknown Patient)	John Doe, Unknown Patient	Simple, widely recognized, historically rooted	Enables rapid registration; familiar to staff	High risk of duplication; no embedded demographic or temporal data; confusing in MCIs
Robinson System (1985)	Alpha One	Modified NATO phonetic first names + written numbers as surnames	>2500 unique combinations; reduces duplication	Requires staff training; not widely standardized
Blank-Reid & Kaplan (1996)	Unknown Abigail	"Unknown" as surname + preassigned human first names	Gender-specific names; avoids impersonal aliases	Limited combinations; possible repetition
Brooks NATO System (1999)	Unknown Male Foxtrot 23/4	"Unknown Male/Female" + NATO phonetic code + admission date	Clear, unique, embeds sex and time; improves communication	May appear complex; requires familiarity with phonetic alphabet
Landman MCI System (2015)	Unk-M-Purple	"Unknown" + sex + unique color/word	Distinct EMR display; tailored for mass casualty	Non-standardized; requires adaptation
Policy Recommendations (NHS, 2018)	Randomized alphanumeric code	Randomised, non-sequential names + unique ID numbers	Prevents duplication; ensures interoperability	Less intuitive for bedside communication
Rogers EMR System (2024)	Patient Ten	"Patient" + room number; DOB defaults (01/01/1910, etc.)	Simple, EMR-compatible	Transfusion errors; lab flagging failures; record merging issues

Future Directions.

Current literature on naming conventions for unidentified patients primarily comprises descriptive studies, institutional reports, and policy recommendations, with a notable absence of comparative evaluations. Future research should focus on systematically comparing different naming systems—such as NATO phonetic-based, randomised alphanumeric, and EMR auto-generated aliases—to assess their impact on patient safety, operational efficiency, and staff usability. Additionally, qualitative studies exploring staff experiences and cognitive load when using various naming systems could inform design improvements. Development of internationally standardised frameworks or guidelines for naming unidentified patients would facilitate interoperability during mass casualty incidents and cross-border care. Integration of technological innovations, such as biometric-linked temporary IDs or EMR-based automated unique alias generators for adults (similar to newborn systems), warrants exploration to enhance accuracy and minimise human error [17]. Finally, implementation science studies are needed to identify barriers and facilitators to adopting structured, standardised naming systems across diverse healthcare settings.

Conclusion.

Unidentified patients represent a small but critically important group within emergency and trauma care, characterised by high rates of trauma, substance misuse, and social vulnerability. While naming these patients is essential for safe clinical care, communication, and legal documentation, current naming practices carry significant risks of duplication, misidentification, and operational errors. Various naming systems have been developed, including NATO phonetic-based aliases, preassigned unique human names, and randomised alphanumeric codes, but robust comparative evaluations remain lacking. This narrative review highlights the urgent need for standardised, evidence-based naming frameworks to minimise patient harm, streamline workflows, and ensure interoperability within and across healthcare systems. Future research and policy development should prioritise evaluating and implementing structured, unique, and universally recognisable naming conventions to enhance safety and dignity for this vulnerable patient population.

REFERENCES

1. Barten DG, Klokman VW, Cleef S, et al. When disasters strike the emergency department: a case series and narrative review. International Journal of Emergency Medicine. 2021;14.
2. Janowak CF, Dolejs SC, Zarzaur BL. Who is John Doe? A Case-Match Analysis. The American Surgeon. 2017;83:294.
3. Thomas P, Evans C. An identity crisis? Aspects of patient misidentification. Clinical Risk. 2004;10:18.
4. Yum H-K. Concept and importance of patient identification for patient safety. Journal of Korean Medical Association. 2015;58:93.
5. Redman CT, Reddy P, Kneifati-Hayek J, et al. Incident Reports of Naming Errors among Two Sets of Infant Twins. Pediatric Quality and Safety. 2020:5.
6. Claps PJ, Berk WA. The John Doe syndrome: Diagnosis and outcome of patients unidentified at the time of emergency department admission. The American Journal of Emergency Medicine. 1992;10:217.
7. Açar D, Tekin FC. The problem of unconscious and unidentified patients in emergency department admissions; a 3-year retrospective study. PLoS ONE. 2024;19.
8. Tastad K, Koh J, Goodridge D, et al. Unidentified patients in the emergency department: a historical cohort study. Canadian Journal of Emergency Medicine. 2021;23:772.
9. Brooks A, Macnab C, Boffard KD. AKA unknown male Foxtrot 23/4: alias assignment for unidentified emergency room patients. Emergency Medicine Journal. 1999;16:171.

10. Robinson GC, Fortune JB, Wachtel TL, et al. A System of Alias Assignment for Unidentified Patients Requiring Emergency Hospital Admission. Journal of Trauma and Acute Care Surgery. 1985;25:333.
11. Janowak CF. Misidentifying the Unidentified. 2019.
12. Janowak CF, Agarwal S, Zarzaur BL. What's in a Name? Provider Perception of Injured John Doe Patients. Journal of Surgical Research. 2019;238:218.
13. Rogers KJ, Blau J, Krasowski MD. Evaluating the utility and challenges associated with "unknown" and fictional patients in the electronic medical record. Academic Pathology. 2024;11:100141.
14. Landman A, Teich JM, Pruitt PB, et al. The Boston Marathon Bombings Mass Casualty Incident: One Emergency Department's Information Systems Challenges and Opportunities. Annals of Emergency Medicine. 2014;66:51.
15. Blank-Reid C, Kaplan LJ. A system for working with unidentified trauma patients. International Journal of Trauma Nursing. 1996;2:108.
16. Dresti S. Positive patient identification. 2024.
17. Riplinger L, Piera-Jiménez J, Dooling JP. Patient Identification Techniques – Approaches, Implications, and Findings. Yearbook of Medical Informatics. 2020;29:81.