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Editorial

Much has been written about the human reality of error. The aptly named "To Err is Human" report acknowledged the fact that mistakes in the medical environment are all too common and while many safety precautions have been implemented since its' publication more than ten years ago, medical error is still a topic of significant interest and discussion in the world of emergency and critical care.

However, the initial problem that supersedes our frailty as humans occurs the moment we don our white coats. In our positions as physicians, clinical professionals and leaders of our departments we are perceived differently- apart from the "humans" we are in our personal lives, we take on a persona which is closer to that of a deity. Our patients expect it, and content with the power it may afford us, we happily oblige. Unfortunately our god-like status forgoes the ability to make mistakes, and often to admit them to our colleagues and patients when they inevitably occur.

"Mistakes are a fact of life. It is the response to the error that counts." Nikki Giovanni (African-American Poet, b.1943)

In this issue we explore some of the myriad of errors and their repercussions that can occur in our departments. Dr. Newman-Toker and his team from Johns Hopkins report on diagnostic errors, where diagnoses are missed, wrong, or otherwise delayed. They discuss the most common misdiagnoses, missed diagnoses and explore the causes of these substantial but often overlooked sources of patient mortality. Timothy Cutler and Patricia Parker delve into medication errors; highlighting results from a recent study on the costs and causes of common errors, identifying high-risk patient groups and offering solution-based approaches, including the use of new technological tools which can be utilised in the administrative processes as well as monitoring of patients. As ethics are an important element of the medical errors equation, we look to Dr. Hébert, a leading author on ethics training to delve into the topic of disclosure and the regulatory and support mechanisms in place in Canada and to offer guidance on strategies to encourage a culture of disclosure in your unit.

In this issue of ICU Management we are also pleased to bring you an interesting comparison of the costs of critical care in varying countries, brought to us by Dr. Wunsch and her team from Columbia University. Her extensive research confirms what has been well documented about the high costs of care in the US, but also points to some other very interesting trends in other countries.

We feature the US in our Country Focus this issue. As a nation headed by a new administration with an outspoken penchant for healthcare change, and which is on the cusp of a national census and also in the midst of economic crisis, perhaps we would also benefit from a renewed overview of the American system in the near future; one which might shed more light on the realistic numbers of citizens, and the true picture of healthcare coverage in the country.

In this issue's Interview, ICU Management Editorial Board Member Prof. Jeffrey Lipman enlightens Managing Editor Sherry Scharff on varying topics from stress in the ICU to how the systemic problem of errors might be remedied and the benefits of the economic downturn in his hospital.

The German Coalition for Patient Safety, a non-profit association of healthcare professionals, institutions and patient organisations, recently published a brochure called "Learning from Mistakes" which describes the frequency and range of medical malpractice in Germany. In it, seventeen members of the coalition describe errors they've made on the job, ranging from late diagnoses of cancer to operations on the wrong knee.

In order to dispel the myth that in our roles in our units we are "gods in white", perhaps we must seek to follow the brave example of our German colleagues, who openly confessed their humanity in an attempt to create a culture of error prevention rather than rely on the current environment of shame and blame. As leaders in our own units and departments, we can choose perhaps not to go so far as to join coalitions, but rather to make our hospitals spaces of open communication and perpetual learning.

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