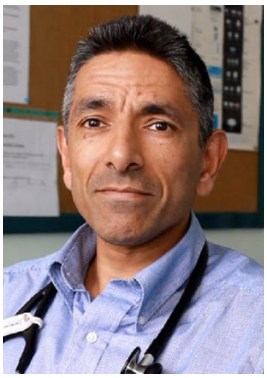

Message from the Editors in Chief

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To err is human.

Error is ubiquitous. We cannot eliminate error completely; we can only manage it and most importantly learn from it.[1]

In this second edition of ***METRIC*** the important topic of error and how we can limit it is addressed. Prevention, the ideal goal, begins from an understanding of how error occurs. Through a comprehensive human factors approach, we can make our environment a safer place for our patients. Alan Gopal, a final year medical student, recounts his average clinical day at the Hull York Medical School. He describes experiences of communication, authority gradients and situational awareness, all key human factors which can have a critical impact on patient safety. It is heartening to see this recognition and importance at the grass roots of clinical training.

Turning to diabetes, a common condition which occurs in one in six patients in the hospital setting, Drs Singh and Allan provide a timely reminder to readers, of the errors which occur in the management of diabetes in hospitalised patients and how to prevent or, at least, minimise such errors. The diabetes in-patient clinical team at Hull and East Yorkshire Hospitals describe how they have successfully reduced the length of stay for in-patients with diabetes and provide important messages for all to translate into clinical practice.

Dr Titterington, once again leaves the daily crossword to pen an article for this second edition of ***METRIC***. His short piece is a topical personal view of the important issues of junior doctors ethical dilemma or indeed moral obligation of raising concerns of error, no matter what the nature in the workplace against the desired no shame, no blame culture. All employees have a responsibility to challenge “unprofessional behaviour” which causes patient harm whether it is within or beyond the NHS, to ensure lessons are learned and feedback occurs.

In the recent cold weather with one of the worst years for mortality in the NHS, Drs Sinha and Purva remind us the importance of warmth even in hospital, in their review of thermoregulation of obstetric patients undergoing surgery. They summarise the key factor to reducing harm is the importance of being familiar with common devices which measure temperature and their significant limitations.

Finally Drs Kar and Aung broach the challenges of diagnosis, the key skill for clinicians in allowing further management. They present the results of a clinical audit studying the diagnostic potential of the DaTscan and how this tool potentially helps to improve the diagnostic accuracy in patients with Parkinsonism, a previous clinical diagnosis only. Failure to diagnose this progressive disorder early can result in delay of effective treatment for patients and such “errors” can have a serious impact for both patients and their families in addition to a loss of confidence in the NHS which should be seen as a safe holistic and competent environment.

We hope the reader finds this important theme of “error” in this edition of the ***METRIC***, as a timely reminder of the different facets of error in the workplace, how it can be managed effectively and the importance of reflecting on one’s practice.

[1] Reason, J (2000) Human error: models and management. *British Medical Journal* 320(7237): 768–770.