EDITORIAL The uses of error

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The article by Chung and colleagues on the discordance between community- and hospital-based ultrasound is striking because of the error rate data. Community based ultrasounds, typically performed by a technician, were discordant for significant genito-urinary abnormalities compared with subsequent hospital based ultrasounds or CT scans in about half of cases. False-positive results were the most prevalent error. The authors conclude that the performance of ultrasound without direct involvement of a radiologist was responsible for the relatively poorer quality of community-based studies.

The article is timely in the context of 2 recent widely publicized episodes of medical error in Newfoundland. Faulty estrogen receptor tests disqualified scores of women with breast cancer in Newfoundland and Labrador from receiving an anti-estrogen. Of 763 patients who tested negative, 317 turned out to be receptor positive, a false negative rate of 42%.

Last month, 2 radiologists in that province were suspended within weeks of one another. The first, Dr. Fred Kasirye, was responsible for misreading hundreds of x-rays. His resignation was followed by a massive undertaking to re-read all of the 2000 studies he had interpreted. A second radiologist was suspended recently, and subsequently reinstated when it was determined that fewer than 10% of the reports were questionable. More recently, the CEO of Newfoundland's Health Authority, George Tilley, resigned over the handling of these issues.

These events increase costs dramatically, and most important, they undermine trust in physicians and contribute to patient anxiety. These errors have led to inappropriate management in some cases. The Chung paper demonstrates that questionable interpretation of imaging studies is not confined to Newfoundland.

All physicians are vulnerable to medical error. In most cases, serious mistakes occur when several safeguards have gone awry. Management theory holds that minor process flaws may point to underlying hazards that are catastrophic under different circumstances. The airline industry recognizes this. When near misses occur, the cause is sought even though both planes landed safely. As an analogy, the fact that the CT scan is not available in the operating room today didn't result in a problem, because the dictated note and ultrasound both identify the correct side of the tumour. Tomorrow, those notes also might not be available, or might contain an error, and the wrong kidney might be removed. Or the wrong drug administered.

In an imperfect health care system operated and managed by human beings, errors occur. The implications are pretty clear. Know your pathologist. Review radiologic and pathologic findings yourself. Be skeptical. Analyze minor glitches to identify systemic problems, and correct them. *Primum non nocere*.

The reception of the first and second issues of the CUAJ and the renal cancer supplement has been great. Thanks to all of the contributors for their manuscripts, the sponsors for their financial support, and our readers, for their enthusiasm. Our managing editor, Josephine Sciortino, is a whirling dervish of energy and competence. We very much appreciate your comments and opinions on the content of the journal.