From the Editor's Desk

AUSTRALIANS DESERVE BETTER THAN THIS

The complexity and chaos of modern health care ensure that the system is constantly at risk of avoidable errors, which cause iatrogenic illness, injury and disability. This continuing threat has spawned a variety of international responses, driven either by a sense of urgency at one end, or by a "softly, softly" approach at the other.

The electrifying US report *To err is human: building a safer health system* galvanised public opinion with its revelation that 100 000 Americans die each year because of medical errors. This seminal report was quickly followed by a purposeful blueprint for reform — *Crossing the quality chasm: a new health system for the 21st century.*

Similarly, British politicians were recently dismayed at the vagueness and bureaucratic obfuscation of the National Patient Safety Agency in responding to the question of how many people die in the United Kingdom from medical errors each year. Failure to produce this information saw heads roll. The UK's Chief Medical Officer, in ordering a shake-up of the services responsible for patient safety, demanded that "more needs to be done to accelerate the pace of change in this area".*

Meanwhile, our initial national response — the Australian Council for Safety and Quality in Health Care of 2000 — has since morphed into the Australian Commission on Safety and Quality in Health Care in 2006. We have also witnessed various safety and quality clones appearing in different jurisdictions.

Despite this flurry of seeming activity, we are yet to have a clear and concrete national enunciation or implementation of a comprehensive range of clinically relevant workplace safety indicators beyond sentinel events, or a timely reporting system for mishaps in safety. It appears that our safety and quality movement is more comfortable to "talk the talk" than "walk the walk".

Where is our equivalent of the US "100 000 Lives" campaign? Where are our national core clinical safety indicators? Where is our effective national mandatory incident reporting and learning system for safety mishaps, or a contemporaneous outcome measurement system? Surely Australians deserve better than this!

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* Kmietowicz Z. Simplify patient incident reporting, says CMO. *BMJ* 2007; 334: 12.

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