The Atlanta Journal-Constitution

"Ask yourself one question. 'Is it right?' Then do what you believe is best for your town, your state and your country." — James M. Cox, founder, Cox Enterprises

FDITORIAL BOARD

Donna B. Hall, Publisher Kevin Riley, Editor

Mark A. Waligore Managing Edito

Andre Jackson Opinion Page Editor

Medicine's lessons can make film sets safer

Checklists prevent teams from making deadly assumptions.

Obviously, Halyna Hutchins was not a patient at a hospi-tal and Alec Baldwin is no doc tor, even if he does play Dr. Robert Henderson in the tele-vision series "Dr. Death." Yet Hutchins' death, unfortunately shares a feature with 173,040 patient deaths in 2019, according to the Centers for Disease





paying bet-ter attention, or punishing the person who made the mistake,

accident.

While some accidents can be prevented through better training.

the common approach of blame, retrain and pledge to do better does not always ensure better results. It does, though, allow people to express sympathy for victims and their loved ones as well as give hope that things will

When multiple people are involved in complex or even cooperative processes, reduc-tion of error is more likely when solutions are sought at the organizational level rather than the individual one. A systems approach will consider the different factors that affect the process of delivering a product or service to improve the way that each task or job interacts safely and efficiently with the overall operation. The recognition that health care should look to sys-

tems-based approaches to



The Bonanza Creek Ranch in Santa Fe, N.M., where actor Alec Baldwin pulled the trigger on a prop gun while filming "Rust" and unwittingly killed a cinematographer. Film sets are chaotic places with murky hierarchies, populated by people with a wide range of abilities and overlapping duties. JAEC. HONO

patient safety came in 1999. when the Institute of Medicine when the institute of Medicine released a startling report enti-tled "To Err is Human: Build-ing a Safer Health Care Sys-tem." This was the first major report that concluded that many hospital deaths occurred as a direct result of errors and accidents. The discovery made the medical profession reconsider its standards of practice, especially in light of its motto primum non nocere (first, do no harm), which serves as the basis of the ethical practice of

edicine. Health care's response to this report was to change the way it examined patient safety. Rather than see medical error as an ad hoc phenomenon, it began to create patient-safety initiatives based on a systems

approach to deal with the

approach to deal with the problem. Of course, with more than 170,000 deaths due to medical error per year, there is still much work to be done. The classic paradigm of a systems-based approach is the "Swiss cheese" model, where an accident can occur only if there is a path in the systems that allow the missale scanes. there is a path in the system that allows the mistake to pass through multiple checkpoints – similar to passing through the holes in how Swiss cheese slices fit together. The key is to create checks that stop the error from pushing through the process. The result is mini-mizing the number of cruss or mizing the number of errors or

Systems-based quality improvement balances mini-mization of risk and increasing redundancies through

additional checks and reviews between various steps in a pro-cess so that the result is a bet-ter and safer product or ser-vice that still maintains effi-

cient delivery. Here is one very simple example of a systems-based technique that could have prevented Halyna Hutchins' death. Atul Gawande wrote a book, "The Checklist Man-ifesto: How to Get Things Right," about the use of check-lists by surgical teams and air-line pilots to avoid mistakes of Inne pilots to avoid mistakes of ineptitude, i.e. those mistakes that come when people do not make proper use of what they know, rather than acting out of ignorance. The checklist serves to ensure that people actually stop and check. It forces the team not to make hasty and team not to make hasty and

deadly assumptions of risk.

The crew on the "Rust" set would typically check the prop would typically check the prop gun, but they reportedly didn't use a checklist. They didn't for-malize the process. And before Halyna Hutchins was shot, the crew member responsible for overall safety on the set didn't properly check the gun. Unlike health care delivery, which is highly structured and regulated, film does not work with groups of licensed profes-

with groups of licensed profes-sionals interacting along clean lines of responsibility and accountability. Film sets are chaotic places with murky hier archies, populated by people with a wide range of abilities and overlapping duties.

Production skills develop through apprenticeships, and the industry resembles some-thing like a guild, with both union and non-union employees. Non-union employees are not necessarily less able than those who have joined a union. One can enter the movie production business in a million ways, including nepotism.
Prior experience is valued but
impartial oversight of such
skills is absent.

Though not obvious, movie production and health care delivery do, however, have important things in comimportant things in com-mon. Both engage in activities requiring the simultaneous work of many individuals per-forming a variety of specific tasks that require training. In both fields, improper safety measures can lead to acciden-tal death. While this recogni-tion led to a transformation in health care, the film indus. in health care, the film industry has not yet learned this

Ira Bedzow is the director of the Mir Yam Institute Project in International Ethics and Leadership in the Center for the Study of Law and Religion at Emory University School of Law, Joel Zivot, M.D., is an anesthesiologist and an associate professor of anesthesiology and surgery at Emory University, and is a senior fellow in the Emory Center for Ethics

Mike Luckovich



READERS WRITE

Both parties guilty of unfair gerrymandering

Re: the AJC Nov. 14 story, "Dems' gerrymandering complaints bring unified GOP response: Remember 200!!," readers may benefit from a more complete view of the last 20 years of gerrymandering. While it is true that the 2001 maps drawn by Democrats were heavily gerrymandered, so were the maps drawn by Republicans in 2011. These maps produced a supermajority in the General Assembly despite Republicans withing a dealing structure.

eral Assembly despite Republicans winning a declining statewide

eral Assembly despite Republicans winning a declining statewide vote share in 2012.

Republicans claim that the 2011 maps were fair because they were pre-cleared by the Obama Justice Department and never challenged in court. Readers should know that the state House and Congressional maps drawn in 2001 were also pre-cleared. Nonetheless, the court overturned those maps. Pre-clearance by itself does not always guarantee fairness. Nor does the lack of a court challenge. The bottom line is that both parties put their thumb on the scale to gain an unfair advantage. This must stop.

to gain an unfair advantage. This must stop. KEN LAWLER, CHAIRMAN, FAIR DISTRICTS GA

Perdue challenge would be good scenario for Dems

Former GOP Sen. David Perdue is considering a primary challenge to Gov. Brian Kemp. If this happens, it will create a split GOP, making way for Stacev Abrams to be elected as the Demo-