



POSITIVE Reflections

We spend most of our time thinking, talking and writing about strategies that will decrease the risk of an aviation accident; introspection generally is confined to the adequacy of our efforts. In the past several weeks, however, I've twice been reminded what an extraordinary achievement the aviation community has accomplished.

First was a report on the effort to introduce checklists into hospital operating rooms. Despite 100,000 post-surgical deaths in the United States alone each year, the medical community has been reticent to alter traditional ways.

The checklist approach, championed by Dr. Atul Gawande in his book, *The Checklist Manifesto: How to Get Things Right*, is being used in fewer than one-quarter of U.S. hospitals.

The checklists detail mostly simple things, such as making sure all necessary staff is present, reviewing the procedure before the cutting begins — a lot like briefing for an approach — and even ensuring the presence of supplies that might be needed, such as extra blood. The process seems very similar to crew resource management.

A test in eight hospitals around the world showed the same results in developing nations and the first world, a one-third

reduction in post-surgical complications and a decline in patient mortality. However, 20 percent of surgeons still think the two-minute checklists are “a waste of time,” Gawande says. Using cockpit checklists as his model, Gawande seems to believe that if captains can be convinced they might be fallible, perhaps doctors' thinking can be likewise swayed.

While the medical community at least is moving towards what we consider sound safety practices, my hometown rapid transit agency, Washington Metro, has suffered a succession of fatal accidents and seems unable to understand why this is happening. A National Transportation Safety Board (NTSB) hearing into a fatal subway train crash in June 2009, killing an operator and eight passengers, made it clear that Metro lacks nearly all of the tools the aviation community now considers essential. NTSB has investigated eight Metro accidents since 2004, and four employees have died in track accidents since the June accident.

Metro's safety manager testified that there is no process for collecting or analyzing safety data; the overall manager of the operation, now on his way out, did not see safety reports until after the big accident last year and, despite operators being repeatedly found in voluntary

noncompliance with operating rules, many report that a punitive safety reporting culture discourages participation.

Metro Chairman Peter Benjamin minimized management's role in establishing a good safety culture, saying, “The best way to change a culture is to work from the bottom up.”

This is not happening in some small, remote location; this agency runs trains and buses in the capital of the United States, including a station in the building that houses NTSB.

The aviation safety community, dedicated to getting better and better, rarely pauses to reflect on achievements, looking, instead, at all that remains to be done. I think it is important occasionally to reflect on the amazing progress that has been made, positive reinforcement motivating future progress. However, I shake my head in wonder about why these lessons cannot more easily be passed along for the benefit of the rest of civilization.

A large, stylized handwritten signature in black ink that reads "J.A. Donoghue".

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