“What Happens When Someone’s Challenge Becomes Everybody’s Challenge”

Zoubir Ouhib MS FACR FABS FAAPM
Annual AAPM 2019
San Antonio TX

Conflict of interest

Speaker for ELEKTA

Learning objectives

- Understand the value of team effort in the world of radiation therapy
- Be familiar with the “playbook concept”
- Discuss the global approach in medical events solutions
AAPM 2019 Annual meeting:
Welcome message from AAPM President Cynthia McCollough

“The theme for the meeting is “Building Bridges, Cultivating Safety, Growing Value.” Come and build lasting partnerships with colleagues and vendors, learn how to cultivate a safety culture, and increase your value to those you work with and to the patients we serve.”

Facts

- As humans, we all make mistakes (Please raise both hands if you don’t)
- Physicists are good in analyzing errors
- We all can come up with different but good solutions
- With our busy schedule, we might not have time to think of solutions for ME that are not ours (or be part of a “playbook”).
- However we might react when reading about a ME: “How can such a thing still happen”?!

New concept (Sort of): “The playbook”

- In sports every coach has a playbook for every game: has tools to guide him for a win (Do good) and avoid mistakes
- In brachytherapy, every team should have a playbook on how to do well (correct ways) and avoid ME’s (Different from how to do a procedure)
- Playbook in sport is created by players, assistant coaches, coaches etc.
- Playbook in radiation therapy (Brachytherapy) is done by a team of medical physicists, radiation Oncologists, and manufacturer representatives willing to provide ideas on corrective/preventive actions on ME.
What happens when a ME occurs?

- Department team will gather and discuss the “who”, “when”, “why”, “how”, and the “now”.
- Can we do better by making that group even larger with people from different institutions, with fresh eyes, and a different approach?

Advantages of the “outside world”

- Small world (Institution) plus the outside world (Other brachytherapy experts): unlimited amount of knowledge and ideas => better solutions
- Different setting, new space, tons of ideas, event looked at by different people in a different way, free from negativity and fear, not limited by the institution comfort zone, people connecting together and thinking outside the box => will create new and better ideas
- People not involved with the case have a better state of mind in analyzing and providing many good practical corrective and preventive solutions.
- “If there is a problem within the mind (Pre-occupied, concerned, has some fear, distracted, exhausted…) how can a mind solves when itself is a problem”? (Thread from physics forums).

The brachytherapy project

- Reported medical errors (Common or severe) are selected from regulatory or reporting systems.
- Case (As reported) is sent to ABS members and representative from the manufacturing industry* to provide feedback and accuracy on the case, corrective actions, preventive actions.
- Institution name, individuals names, etc. are removed from the case
- Focus:
  a) First we try to understand the case then look at the “when”, “what”, “how” and not on who did it. All about the process.
  b) Second we look at corrective and preventive actions; check with manufacturer for any helpful documentation, clarification, and feedback
  c) Feedback and solutions are tabulated and sent back to all reviewers for additional comments and approval
  d) Final clean summary sent to all members (Only constructive criticism is allowed).
Challenges

- ME report information might not be clear or accurate
- Information lacking some valuable details
- Unless information is complete, difficult to provide applicable corrective/preventive actions

Status of the project

- Five cases have been discussed so far: total length, catheter reconstruction (2), activity error, and source (eBT) calibration errors.
- One case per month is presented
- Feedback is sent to: PreventMedEvent@gmail.com (Soon to be PreventMedEvent@ABS.org)
- Cases are published in the ABS BrachyBlast newsletter
Immediate actions

Medical Event Case 5880 Responses and Feedback from Enron Passengers

In response to case 5880, we are eager to present the feedback and provide recommendations that we have collected from various stakeholders.

What Happens When Someone’s Challenge Becomes Everybody’s Challenge?

• We all learned from each other that could help us prevent a similar ME (Or perhaps a different one).
• Valuable dialogue among people to brainstorm and be creative for practical solutions in a collegiate environment.
• Engage manufacturers in the discussion and as a team look into preventive/corrective actions (Product/software development and improvement).
• Alert regulators/AU on the need for an accurate reporting (details, accuracy, etc.) for applicable and better solutions.
• Create a playbook for everyone to adopt for a safer/better patient outcome.

Long Term actions

A spreadsheet for secondary calculations relates to the decay of the radioactive material should be provided as a reference for accuracy.

Immediate (long-term) actions:

• We all learned from each other that could help us prevent a similar ME (Or perhaps a different one).
• Valuable dialogue among people to brainstorm and be creative for practical solutions in a collegiate environment.
• Engage manufacturers in the discussion and as a team look into preventive/corrective actions (Product/software development and improvement).
• Alert regulators/AU on the need for an accurate reporting (details, accuracy, etc.) for applicable and better solutions.
• Create a playbook for everyone to adopt for a safer/better patient outcome.

Immediate (short-term) actions:

• We all learned from each other that could help us prevent a similar ME (Or perhaps a different one).
• Valuable dialogue among people to brainstorm and be creative for practical solutions in a collegiate environment.
• Engage manufacturers in the discussion and as a team look into preventive/corrective actions (Product/software development and improvement).
• Alert regulators/AU on the need for an accurate reporting (details, accuracy, etc.) for applicable and better solutions.
• Create a playbook for everyone to adopt for a safer/better patient outcome.
What Happens When Someone’s Challenge Becomes Everybody’s Challenge (Cont’d)

- **Build bridges**: partnership with colleagues, vendors, and regulators
- **Cultivate the safety culture**
- **Aim** for better outcome for our patients

**Conclusion**

- Medical events are not going away
- It is up to all of us to reduce them and make them inconsequential if they were to occur
- More participation by all (Radiation Oncology team, manufacturers, and regulators) will improve the reliability of the proposed solutions
- When someone’s challenge becomes everybody’s challenge => patients will benefit

*When you hand good people possibility, they do great things.*

Biz Stone